

Exhibit A

1 IN THE U. S. DISTRICT COURT
 2 MIDDLE DISTRICT OF ALABAMA
 3 NORTHERN DIVISION
 4
 5 JOHNNY W. SASSER,
 6 PLAINTIFF,
 7 VS. CASE NO: 2:06-CV-593-CSC
 8 RYDER TRUCK RENTAL,
 9 et al.,
 10 DEFENDANTS.
 11
 12 The deposition of DR. J. JERRY
 13 MARSELLA, JR., taken by the Plaintiff,
 14 pursuant to the Federal Rules of Civil
 15 Procedure, before Stacey Watkins, RPR, and
 16 Notary Public, State at Large, at the offices
 17 of Anesthesia Consultants Medical Group,
 18 Dothan, Alabama, on the 20th day of July,
 19 2007, at 7:10 a.m., CDT, pursuant to notice.
 20 * * * * *
 21 APPEARANCES:
 22 FOR THE PLAINTIFFS: FOR THE DEFENDANTS:
 23 MS. AMY M. SHUMATE MR. CONLEY W. KNOTT
 24 Attorney at Law Attorney at Law
 25 Dothan, Alabama Birmingham, Alabama
 ALSO PRESENT:
 JOHNNY SASSER

1 DR. J. JERRY MARSELLA, JR.
 2 having been first duly sworn, testified as
 3 follows, to-wit:
 4

EXAMINATION

7 BY MS. SHUMATE:

8 Q Dr. Marsella, my name is Amy
 9 Shumate, and I represent Johnny Sasser in a
 10 lawsuit that's been filed regarding his
 11 workers' comp claim. I'm going to be asking
 12 you questions. And, of course, I know you've
 13 done this before. But, if, at any time, you
 14 don't understand the question, certainly let
 15 me know --

16 A Certainly.

17 Q -- and I can rephrase it. Would
 18 you please state your name for the record?

19 A John Jerry Marsella, Jr.

20 MS. SHUMATE: And for the record,
 21 the attorneys have stipulated,
 22 prior to going on the record,
 23 Dr. Marsella's qualifications
 24 as a physician and his
 25 licensing, and we have agreed

STIPULATION

3 It is stipulated by and between counsel
 4 for the parties that this deposition be taken
 5 at this time by Stacey Watkins, RPR, and
 6 Notary Public, State at Large, who is to act
 7 as commissioner without formal issuance of
 8 commission to her; that said deposition shall
 9 be taken down stenographically, transcribed,
 10 and certified by the commissioner. The
 11 signature of the witness is waived.

12 Except for objections as to the form of
 13 questions, no objections need be made at the
 14 time of the taking of the deposition by
 15 either party, but objections may be
 16 interposed by either party at the time the
 17 deposition is read into evidence, which
 18 shall be ruled upon by the Court on the
 19 trial of the cause upon the grounds of
 20 objection then and there assigned.
 21
 22
 23
 24
 25

1 to attach his CV to this
 2 deposition as Plaintiff's
 3 Exhibit No. 1.

4 Q Now, I would like to ask you a
 5 couple of questions about your specialty.
 6 You are a physician, licensed in Alabama?
 7 Correct?

8 A Yes.

9 Q Do you have an area of specialty in
 10 medicine that you practice in?

11 A My primary specialty is
 12 anesthesiology, and my subspecialty is pain
 13 management.

14 Q Okay. Now, what, specifically,
 15 does it mean to have a subspecialty in pain
 16 management?

17 A That implies extra training in that
 18 area, in this case, pain management, which,
 19 in my case, was a six-month postgraduate
 20 fellowship with concentration in all aspects
 21 of pain medicine and pain management.

22 Q And what does a pain management
 23 doctor do? What do you do for your patients?

24 A We handle, primarily, chronic pain
 25 problems, but we also do some acute

1 postoperative pain management. The chronic
2 pain problems are anything from back pain to
3 headache to special types of nerve pain to
4 basically all kind of pain. We manage those
5 by using various techniques and methods,
6 including injections, physical therapy,
7 occupational therapy, medications.

8 Q So, is it a fair statement that
9 you're not necessarily in the business of
10 curing the problem, but helping them live
11 with the pain that's associated with it?

12 A Yes.

13 Q Okay. And are you board certified
14 in anesthesiology?

15 A I am.

16 Q Is there a board certification for
17 pain management?

18 A Yes, there is, and I'm board
19 certified.

20 Q All right. Is that a separate
21 certification?

22 A It is.

23 Q How long have you practiced in the
24 area of pain management?

25 A In private practice 16 years.

1 today, Mr. Sasser had already settled his
2 case with the workers' comp company regarding
3 that back injury, and they were ordered to
4 continue to pay medical treatment that was
5 related to that back injury on the job.

6 Now, was he referred to you by another
7 physician?

8 A Let me look.

9 Q Sure.

10 A Typically, they are. At that time,
11 our primary way of obtaining patients was by
12 referral. And I didn't refer in my notes
13 specifically to the referring physician. Let
14 me look.

15 Q I had in my notes -- and I
16 certainly want you to look for yours -- that
17 it was Dr. Wallace McGahan. But if you would
18 check and make sure that's what you
19 understood.

20 A Yes. Yes.

21 Q So, Dr. McGahan sent him to you to
22 treat what part of the body, was your
23 understanding at that time?

24 A I don't know specifically.

25 Typically, the request is worded "evaluate

1 Q All right. Now, you have had an
2 occasion to see and treat Mr. Johnny Sasser?
3 Is that correct?

4 A I have.

5 Q Can you tell the jury when the
6 first time was that you saw Mr. Sasser, and
7 what the reason for his visit was?

8 A Mr. Sasser's first visit here, not
9 in this particular building, but with our
10 practice, was on September the 5th of the
11 year 2000. He came in with the chief
12 complaint of low back pain, had diagnosis of
13 degenerative disc disease of the lumbar spine
14 and lumbar spinal stenosis.

15 The history that he gave was that he had
16 been dealing with his pain since 1995, at
17 which time he said that he was doing his
18 usual work, and he was helping to lift a
19 motor, an 800-pound motor, at the General
20 Electric plant. And while he was attempting
21 to lift the motor and secure it, he strained
22 his back, and since that time, he had had the
23 back pain and the problems with his back.

24 Q Okay. Now, to bring you up to
25 speed, so you'll know what we're doing here

1 and treat." Sometimes they'll put in
2 specific area. But, at the time, the pain
3 was primarily where he stipulated. Now, I do
4 have here -- let's see. This is written on a
5 prescription. Unfortunately, it's -- it says
6 September the 5th, 11:30. So, I'm assuming
7 that was the time of that appointment.

8 At the bottom, it says, "Diagnosis,
9 spinal stenosis and carpal tunnel syndrome."
10 Written on the bottom of that is "sciatica,"
11 "HNP," which is herniated nucleus pulposus,
12 or a disc, "LS spine," lumbosacral spine.
13 And this, I think, is Dr. McGahan's
14 signature.

15 Q Is that on a note from
16 Dr. McGahan's office?

17 A It's on a prescription sheet.

18 Q Okay. And that's Dr. McGahan's
19 prescription pad?

20 A It is. It has his name at the top.

21 Q And is that note there part of your
22 file?

23 A It is.

24 Q And is that the type of things that
25 you have in your file that you keep in the

1 regular course of your business?

2 A It is.

3 Q And is the information contained on
4 that note the type of information you receive
5 from referring physicians that you review and
6 use in your evaluation and treatment of the
7 patient?

8 A Yes.

9 Q All right. And did you do so in
10 this case?

11 A I did.

12 Q All right. So, basically, it
13 appears as if he was sent here by Dr. McGahan
14 for back problems, and you're evaluating him
15 and treating him for what he reported to you
16 to be back pain?

17 A Yes.

18 Q Okay. Now, the carpal tunnel was
19 not part of his settlement, so we won't
20 really deal with any of your treatment, if
21 any, dealing with carpal tunnel.

22 A Okay.

23 Q We're specifically dealing with the
24 back.

25 A Okay.

1 Zanaflex, four milligrams, three times a day,
2 and then, just set the patient to come back
3 in a month for a follow-up visit.

4 Q All right. Do you have any other
5 medical records from Dr. McGahan, or did the
6 group send any, or did Mr. Sasser bring in
7 any other medical records that dealt with
8 this injury, for you to know how long he had
9 been treating or what types of treatment he
10 had had in the past?

11 A The only thing that I had from
12 outside were some faxed records, which are
13 difficult to read, because they transmitted
14 poorly.

15 Q Who faxed those to you? Do you
16 know?

17 A Again, the header, you can't really
18 read, because it didn't transmit well. Now,
19 I have another fax sheet here, but this was
20 dated 3-1-02, so that doesn't have to do with
21 the initial visit. Really, it's hard to
22 read.

23 Q So, that fax note that's hard to
24 read really wasn't part of your --

25 A It wasn't something that I relied

10

1 Q Would you go through -- I guess,
2 after your history that he gave you in
3 September, did you do an examination?

4 A I did.

5 Q And what did you do for the exam,
6 and what were the results of the examination?

7 A A sort of general physical exam
8 showed, for the most part, things were
9 reasonably normal, as far as his heart and
10 lungs and those sorts of things.

11 On neurological examination, there was
12 some decreased sensation to light touch -- I
13 didn't do pinprick at the time -- in a
14 nonradicular pattern of the right leg
15 compared to the left. "Nonradicular" meaning
16 it didn't follow, necessarily, specifically,
17 the pathway that a particular nerve root
18 would follow on a normal -- what we call a
19 dermatome chart.

20 Q Okay. What did you do after that
21 exam?

22 A The first thing that I did was to
23 initiate a trial of pain medication,
24 Methadone 2.5, or two and a half milligrams,
25 three times a day, a muscle relaxer,

12

1 on to help me make my decision.

2 Q That's what I needed to know. All
3 right. Now, I heard you state that you gave
4 him Methadone. Now, for members of the jury
5 who might not understand the use of Methadone
6 other than for treatment of someone who's
7 addicted to methamphetamines, would you
8 explain that to them, please, why Methadone
9 would be prescribed?

10 A Methadone is an excellent
11 analgesic. Initially, it was developed for
12 that purpose, not for rehabilitation. The
13 advantage of Methadone in a chronic pain
14 patient is twofold, really.

15 One is that, because of the way the body
16 handles the medication, it stays in the body
17 for a long time. So, it has the ability to
18 have a prolonged relief.

19 The other thing is that, because of its
20 chemical nature, it can treat certain special
21 kinds of pain, particularly nerve-type pain.
22 Not necessarily specifically for -- it's not
23 used necessarily specifically for that type
24 of pain. In other words, some patients get
25 that medication even if they don't have a

1 nerve-generated pain.

2 But the basic reason for a medication
3 like Methadone is, number one, it's
4 effective. Number two, it can have a
5 prolonged effect. And, number three, from an
6 economic standpoint. It's very cost
7 effective.

8 Q All right. Did you follow up with
9 Mr. Sasser -- did he follow up with you, I
10 should say, following that initial visit?

11 A He did. Now, at the time that Mr.
12 Sasser was coming to the pain center, we
13 typically would dictate notes. And I have
14 some handwritten nurse's vital signs from
15 several dates, October the 17th of 2000,
16 January the 4th of 2001. But, unfortunately,
17 I don't have dictated notes from those days.
18 I can't tell you why. The next dictated note
19 that I have is January the 30th of '01.

20 Now, let me just interject here, in
21 another part of the record, we have a
22 medication log. And for those dates that I
23 mentioned --

24 Q Yes.

25 A -- I do have, in my log, that he

14

1 received, again, the medication, the
2 Methadone. And it's reflected here that the
3 dosage was upped from two and a half
4 milligrams, three times a day, to five
5 milligrams every eight hours, or three times
6 a day.

7 Also, a change was made from Zanaflex to
8 Baclofen, which is another muscle relaxer of
9 a similar nature and of a comparable
10 strength. That was dated 9-5, 2000 and 9-27,
11 2000.

12 Q Okay. Now, if I could, I want to
13 show you what I've received. The defense
14 attorney subpoenaed records from the Medical
15 Center --

16 A Right.

17 Q -- and that covered yours. And as
18 part of that, I've received a dictated note
19 from 9-27. Does that appear to be --

20 A Yes.

21 Q -- your dictated notes?

22 A (Witness nodding head in
23 affirmative.)

24 Q Were those kept separately than the
25 chart you have here?

1 A Yes. This is sort of a tortuous
2 system that we have. The hospital is the
3 owner of the pain management center facility
4 itself, and so, any records generated within
5 the facility are official hospital records.
6 And, as such, they become part of the
7 patient's permanent hospital record.

8 However, because of policy, those
9 physical charts can't leave the hospital
10 building. And since our clinic building is
11 physically separate, the only way for us to
12 have access immediately to the patient's
13 record, without having to send someone across
14 to the hospital, is to have our own -- what
15 we call convenience record, which has
16 everything that we generate out of the pain
17 center.

18 And, actually, there are some things in
19 this convenience record that may not be up to
20 this point in the hospital record, such as
21 lawyer letters, insurance company letters,
22 things that don't necessarily have to do with
23 official hospital business, that really are
24 only unique to our pain practice.

25 Our current practice, now, is that we

16

1 basically scan everything into the patient's
2 record. But, in essence, this is only for
3 our convenience, and it's not the official
4 record.

5 Q But it is a record kept here in
6 your office --

7 A Yes.

8 Q -- in the normal course of your
9 business?

10 A Yes. And, normally, we should have
11 these. As I said, I can't explain why they
12 aren't in here.

13 Q All right. I would like to have
14 that stack of documents from 9-27, 2000,
15 admitted as Plaintiff's Exhibit No. 2, so we
16 will have them attached to your deposition.
17 But, if you would, could you review them
18 now and --

19 A Sure.

20 Q -- let's talk about that visit?

21 Now, I'm going to -- for the sake of brevity
22 and for the sake of the jury's understanding,
23 I would prefer not to necessarily go through
24 visit by visit, unless you need to.

25 A No, I don't.

1 Q Once we get past the first few
2 visits, if you could just explain your
3 general course of treatment --

4 A Sure.

5 Q -- and how he fared with you, that
6 would be more natural in the way we talk
7 about things.

8 A Let me just take a look at this
9 real quick.

10 Q Sure.

11 A In essence, I followed Mr. Sasser
12 on an average of every three months, with an
13 occasional visit in between those. The main
14 modalities during that time were medication
15 management, with an occasional trigger point
16 injection for some complaints of muscle
17 spasms in the legs.

18 Q Okay. Can you explain the trigger
19 point injections to the jury?

20 A Certainly. A trigger point
21 injection is an injection into the muscle
22 with a small amount of, in our case, local
23 anesthetic and anti-inflammatory steroid
24 medication, the purpose of which is to quiet
25 down an inflammatory process in the muscle

18

1 which can lead to localized pain.

2 Q The pain that you saw him exhibit
3 and the muscle spasms and things of that
4 nature that you document, are they consistent
5 with the original diagnosis that was sent
6 from Dr. McGahan of the lower back pain, the
7 spinal stenosis, and things of that nature?

8 A Yes. But, in some cases of people
9 who have a back problem, because the pain may
10 alter their gait, that may pose more of a
11 strain on certain muscles, which cause the
12 muscle pain.

13 Q Okay. So, the muscle spasms are a
14 result of an altered gait?

15 MR. KNOTT: Object to the form.

16 A They can be.

17 Q In his situation, did you have an
18 opinion as to what was causing the muscle
19 spasms that required the trigger point
20 injections?

21 A Not really, other than what I just
22 said.

23 Q Was there anything that was unusual
24 about that presentation to you --

25 A No.

1 Q -- or that gave you concern?

2 A (Witness shaking head in negative.)

3 Q Okay. Now, I would want you to
4 assume, hypothetically, because you don't
5 have the records in your chart, that, on
6 September the 13th, 2000, which was a few
7 days after your first visit with Mr. Sasser,
8 that Dr. McGahan, who was his workers'
9 comp-approved treating physician, has a note
10 in his chart indicating the diagnosis for Mr.
11 Sasser was low back pain, muscle spasms, CAD,
12 and spinal stenosis. Is that also your
13 understanding of his diagnosis when you were
14 treating him?

15 A Well, the CAD, the typical meaning
16 for that is coronary artery disease, which --

17 Q Has nothing to do with his back?
18 Is that pretty much correct?

19 A That's right.

20 Q But the lower back pain, muscle
21 spasms and spinal stenosis is consistent with
22 your treatment?

23 A Yes.

24 Q Now, you treated him from September
25 of 2000 until when?

20

1 A The last note that I have is dated
2 5-20-04, May 20th of '04.

3 Q Okay. And in between September of
4 2000 and May 20th of '04, were you treating
5 him for the same thing, the lower back pain,
6 the spinal stenosis, and the muscle spasms?

7 A Yes.

8 Q Was there anything during that time
9 that changed about his condition, where you
10 were treating him for something other than
11 what he was originally referred by
12 Dr. McGahan for?

13 A No.

14 Q Okay. And your treatment, I
15 believe you said, was basically --

16 A Medication.

17 Q -- medication and occasional
18 trigger point injections?

19 A Yes. That's correct.

20 Q In your opinion, was the medication
21 and the occasional trigger point injections
22 necessary to treat the chronic back pain that
23 he was sent here by Dr. McGahan for?

24 A Yes.

25 Q In your opinion, were those

1 medications directly related to the back
2 injury that he had suffered?

3 MR. KNOTT: Object to the form.
4 Object to the leading.

5 A Yes.

6 Q The judge in this case, back in
7 Barbour County, basically had asked that
8 Dr. McGahan review all the medicals and
9 determine whether there was an injury on the
10 job, and report to him.

11 And Dr. McGahan submitted a letter to
12 the judge that basically said, "Mr. Sasser,
13 in my medical opinion, received a
14 work-related injury on or about September the
15 8th, 1995. I reached this opinion after
16 several office visits and examinations.

17 I do not believe Mr. Sasser has anything
18 to gain from a neurological examination at
19 this time, although I will be happy to
20 schedule him a visit or visits.

21 In my opinion, Mr. Sasser's approximate
22 medical expenses should be \$10,000.00 per
23 year. I could elaborate on the nature of his
24 injury, if necessary. So, if more
25 information is needed, please let me know."

22

1 And that was dated January the 3rd of
2 2000. Do you have any information at all,
3 either from Mr. Sasser's presentation, from
4 any other source, from your own observations,
5 examinations of him or anything, that lead
6 you to believe Dr. McGahan was incorrect when
7 he stated that he had received an on-the-job
8 back injury in 1995?

9 MR. KNOTT: Object to the form and
10 the predicate. Based on
11 hearsay.

12 A Well, from my standpoint --

13 Q Yes.

14 A First of all, I didn't have access
15 to that information. But, second of all, you
16 know, when a patient presents to us or any
17 physician and states the reason for their
18 visit, we have to believe what they say is
19 true.

20 And when Mr. Sasser came in, he said
21 that the reason he had his back pain was
22 because he was involved in a work-related
23 accident, lifting a large motor at the
24 General Electric plant.

25 Q Sure.

1 A So, as far as I was concerned, that
2 was the reason that he had his back problem.
3 Q And before he came to you -- again,
4 you may or may not be aware of this. Before
5 he came to you, there had been a settlement
6 and a finding of fact and an order.

7 And, specifically, there was one, I
8 believe, in 1998. And then, again, in 2000,
9 the judge specifically found that the
10 plaintiff sustained a back injury as a result
11 of an accident which occurred on or about
12 September the 8th, 1995, which arose out of
13 and in the course of plaintiff's employment.

14 And then, the judge issues an order
15 stating that the defendant shall continue to
16 be responsible for future medical expenses as
17 provided in paragraph three, which is future
18 medical expenses related to that injury.

19 Assume, hypothetically, for me, now that
20 you know Dr. McGahan's opinion that it was
21 work related, the judge has issued an order
22 that it was work related, and that that
23 work-related injury was to his lower back.
24 And you now know Dr. McGahan's diagnosis at
25 the time he sent him to you.

24

1 In your opinion, is the condition you
2 were treating him for the same condition that
3 it appears Dr. McGahan had been treating him
4 for and that the judge issued an order
5 regarding?

6 MR. KNOTT: Object to the form.
7 Object to the hypothetical and
8 the predicate. Object to the
9 leading.

10 Q Assuming those facts are true.
11 Assuming what I read to you was --

12 MR. KNOTT: Same objection.

13 A Well, all I know is that -- yes, I
14 assume that they were the same. But, again,
15 when Mr. Sasser came in, he told me that his
16 back hurt --

17 Q Sure.

18 A -- that he got hurt on the job.
19 And that's what I knew.

20 Q Sure. Now, during the course of
21 your treatment of him, did you have him --
22 when he's taking his medication, are these
23 scheduled medications, meaning they have to
24 be regulated in the disbursement of them?

25 A Yes.

1 Q And did you, as part of your normal
2 practice, monitor a patient's medication and
3 medication level to see that they're not
4 taking too much medication and things of that
5 nature?

6 A I did.

7 Q Okay. Was there anything in Mr.
8 Sasser's chart or anything that you observed
9 in him through testing or through your
10 observations directly that made you feel that
11 he was exaggerating or malingering in his
12 symptoms in any way?

13 A Well, the purpose of our monitoring
14 of medication, and, in our case, the use of
15 urine drug screens, really is only a purely
16 objective test to determine the presence or
17 absence and the levels of certain medication.
18 Really doesn't address or even look into the
19 reasons for the medications or the incentives
20 or disincentives of a particular patient.

21 I understand your question. As I
22 understand your question, was I using the
23 testing to determine whether he was
24 legitimate. That's not the reason. The
25 reason is to determine, just like you --

1 Q If he was taking it or he was
2 taking too much of something else?

3 A Just like you check a person's
4 blood sugar to monitor whether they are
5 getting enough diabetic medication.

6 Q Before you prescribe medication
7 such as Methadone and Oxycontin and other
8 medications for a patient, do you make an
9 independent determination that, in your
10 opinion, they need that medication for their
11 medical condition?

12 A Yes.

13 Q And that they have a legitimate
14 medical need for it --

15 A Yes.

16 Q -- rather than just someone who's
17 addicted, and comes to a doctor, pain seeking
18 -- I mean, medication seeking?

19 A Yes. Well, we make an effort to do
20 that.

21 Q Is that a concern of yours to make
22 sure patients aren't coming here --

23 A Just to get medication?

24 Q -- just to get medication, just to
25 get these controlled substances?

1 A Yes. Oh, it's a great concern of
2 ours.

3 Q Was there anything about Mr.
4 Sasser's presentation or history or
5 information you learned during his case that
6 made you think he was here simply for the
7 purpose of seeking controlled substances?

8 A No.

9 Q Okay. Now, you saw him last in May
10 of '04?

11 A Yes.

12 Q Do you have anything in your record
13 to indicate why his treatment stopped?

14 A He just didn't come back.

15 Q Okay. Do you have knowledge as to
16 whether the workers' compensation carrier, or
17 the company who was paying for his medicals,
18 decided to no longer pay for that treatment?

19 A I have no knowledge of that.

20 Q I have a letter dated July 12th of
21 2004, that was sent from Intracorp, allegedly
22 addressed to you.

23 A And I allegedly have it in my
24 chart.

25 Q And you do have that note in your

1 file?

2 A I do.

3 Q If we could go over it. It
4 basically is a letter denying your request
5 for office visit for medication management.
6 They state -- the rationale in the letter is
7 stated as, "The claimant has low back pain.
8 It is" -- no. Your rationale, I'm assuming.
9 "... low back pain. It is worse with riding
10 long periods of time. TPIs" -- I'm not sure
11 what TPI is. Do you know what that means?

12 A Trigger point in injections.

13 Q Okay. -- "were given 1-20-04 and
14 5-20-04. He is taking Oxycontin and Valium.
15 There is insufficient recent objective
16 documentation of the claimant's response to
17 the TPIs of 5-20-04 to determine if
18 medications are still needed in support of
19 the request. There is insufficient
20 documentation of failed conservative
21 treatment to support the necessity of the
22 request, such as daily compliance with the
23 home exercise program."

24 So, basically, this is their rationale,
25 apparently, for denying your request for a

1 preapproval of this treatment.

2 A Uh-huh.

3 Q And the treatment you were asking
4 for was another trigger point injection or
5 just continued pain management? Do you know?

6 A I would assume that, from the
7 wording in the letter.

8 Q Okay. In your opinion, was the
9 treatment you were requesting from -- for
10 your office visit that you requested of them,
11 in your opinion, was that necessary --

12 MR. KNOTT: Object to the form.

13 Q -- for his ongoing pain management
14 related to his back problems?

15 MR. KNOTT: Object to the
16 hypothetical.

17 Q I'm going to go on the record right
18 now. I mean, I'm asking you -- I'm not
19 hypothetically asking you anything. I'm
20 asking you, in your opinion -- am I correct
21 that your office requested, I guess through
22 the normal channels, a preauthorization for
23 treatment for Mr. Sasser through workers'
24 comp? Is that correct?

25 MR. KNOTT: Object to the form and

30

1 foundation.

2 A I would assume so.

3 Q And if you did that, would you be
4 asking for preapproval of something you
5 thought was medically necessary for him?

6 MR. KNOTT: Object to the form and
7 foundation.

8 A Yes.

9 Q In your opinion, was the treatment
10 that you requested that they pay for here,
11 that they denied, a necessary treatment for
12 his pain management for his back injury?

13 MR. KNOTT: Object to form,
14 foundation and leading.

15 A Yes.

16 Q Okay. Do you agree with their
17 rationale for having denied that? That they
18 didn't think there was sufficient objective
19 documentation of his response to the trigger
20 point injection?

21 MR. KNOTT: Object to the form.

22 Q Do you agree with that rationale?

23 MR. KNOTT: Object to the form.

24 A Well, since I don't know what their
25 guidelines are, going into it, for sufficient

1 objective documentation, it would be hard for
2 me to say whether I agree with it or not.

3 Q Was there sufficient information
4 for you to ask for that continued treatment?

5 A Yes.

6 Q Okay. And as his treating
7 physician, in your opinion, would that be
8 your decision to make, whether he needs
9 medical treatment? Regardless of whether
10 they're going to pay for it or not, is it
11 your decision, in your opinion, to decide
12 what he needs medically?

13 MR. KNOTT: Object to form and
14 foundation.

15 A Yes.

16 Q When you last saw him, in May of
17 '04, was it your understanding and your -- I
18 guess this. Did you have an opinion or an
19 expectation that Mr. Sasser was continuing to
20 treat with you as he had done for the last
21 four years? That he would continue to treat
22 with you?

23 A Yes. As a matter of fact, I've got
24 a little handwritten addendum on the note
25 dated -- well, not dated, but on that day,

32

1 that says, "Follow-up already set." So,
2 apparently, having asked for Mr. Sasser to
3 come back another time, the secretary had put
4 that appointment on our books.

5 Q And is that the normal course for
6 your office, that, when they're here, and
7 they're going to do a follow-up, your
8 secretary goes ahead and schedules the next
9 appointment?

10 A Yes.

11 Q Okay. Was there anything that had
12 changed about Mr. Sasser's condition from
13 2000 to the May 2004 that made it no longer
14 necessary for him to need this treatment for
15 his back pain?

16 A Not that I could tell.

17 Q Did he suddenly get better to the
18 point that he would not need to come in for
19 pain management?

20 A Not that I could tell.

21 Q At the time that they denied him
22 continued treatment, can you tell the jury
23 what medication he was taking, what
24 prescriptions you had given for him?

25 A Well, I can tell you, on that

1 particular date, based on our log. The last
2 prescriptions that I have logged in are
3 actually 6-18-04, and, just prior to that,
4 5-18-04. The medication was Oxycontin, 40
5 milligrams, one every eight hours.

6 He had also, prior to that, in December,
7 December the 29th of '03, had been issued a
8 prescription for a medicine, Topamax, which
9 we use sometimes as an adjunct medication,
10 or an additional medication for certain types
11 of pain, one to two at bedtime. 62 pills
12 prescribed with as-needed refill. So, that
13 meaning he wouldn't have needed another
14 prescription for another year.

15 Q Now, the Oxycontin, how long had he
16 been taking Oxycontin prescribed through your
17 office?

18 A First prescription for that was
19 January the 30th of '01.

20 Q Was that something he took, then,
21 consistently, or at least was prescribed
22 consistently from '01 until '04?

23 A Yes.

24 Q If you decide to take a patient off
25 of Oxycontin, do you have any prescribed

1 through withdrawal or experience what's
2 called an abstinence -- acute abstinence
3 syndrome.

4 Q And can you describe what that
5 withdrawal or abstinence syndrome typically
6 -- how it presents?

7 A Well, it usually presents as
8 agitation and anxiety, cold sweats, GI
9 cramping, diarrhea, sometimes headache,
10 sometimes difficulty sleeping. Typically,
11 these things start about -- anywhere from
12 three to five days after the medication is
13 stopped, and they usually last for three to
14 five days.

15 Q In Mr. Sasser's situation, when the
16 workers' comp company -- or when the
17 defendant in this case, Ryder, no longer
18 approved your treatment, they no longer
19 approved medication prescription refills, as
20 well.

21 Would you expect Mr. Sasser, having been
22 on Oxycontin for more than three years, if he
23 was simply cut off, without weaning him,
24 would you expect he would experience the
25 withdrawals that you've talked about?

1 protocols you follow in -- especially someone
2 who has been on the medication for over three
3 years, for taking them off of that
4 medication?

5 A Usually, if someone is going to
6 voluntarily come off of a medication -- and
7 not just with opioids, but typically other
8 medications, as well, we'll use a weaning
9 protocol. There's no specific percentage or
10 milligram dosage. It just depends on what
11 the patient is taking.

12 But, typically, every three to five to
13 sometimes seven days, the dose will be
14 decreased by a little bit, until such time as
15 the medication is completely discontinued.

16 Q And why do you do a weaning process
17 with those medications, in particular,
18 Oxycontin?

19 A Well, particularly with the opioids
20 -- not just Oxycontin, but with all of the
21 opioids -- one of the things that we're
22 concerned about in patients who are using
23 these sorts of medications long term, they
24 can develop physical dependence. And if the
25 medication is stopped suddenly, they can go

1 MR. KNOTT: Object to the form and
2 predicate. Improper
3 hypothetical.

4 A It's not consistent. In other
5 words, it doesn't happen to everybody. I've
6 seen people who are on much larger doses of
7 medication stop suddenly, for whatever
8 reason, and not have any problem with that.
9 I've seen people who are on much smaller
10 doses have what we call microwithdrawal
11 between doses of medication that they
12 continue to be on.

13 So, in essence, the answer is, I
14 wouldn't expect it, but I wouldn't be
15 surprised. I neither expect it nor unexpect
16 it, if you will.

17 Q Okay. He answered some
18 interrogatories that the defendant asked him
19 over a year ago, certainly before he sat in
20 here today and heard your testimony, and
21 stated that he laid in a hospital bed at home
22 in cold sweats, unable to eat, taking bottles
23 of nitro tablets, vomiting, diarrhea, cramps,
24 thinking I was dying. And that's his
25 description of when he suddenly stopped

1 taking the Oxycontin, because Ryder cut him
2 off.

3 Does that sound consistent with what you
4 would expect, if someone, in fact, went
5 through that type of withdrawal? That
6 description of it?

7 A Yes.

8 Q Okay. Is that a pleasant
9 experience, based on what you've seen?

10 A I've never been through it.

11 Q Have you had patients describe it
12 to you?

13 A I would assume that it is. I have
14 had it described as unpleasant. But, having
15 no personal experience, I can't say that it
16 is or not.

17 Q But, as a physician, you do your
18 best to stop that from happening for a
19 patient?

20 A Certainly.

21 Q Okay. Because it's not something
22 that you, as a physician, would like to see
23 your patients go through?

24 A Exactly.

25 Q Okay. Now, I'm going to ask you

1 focus in pain medicine and pain management
2 is, I couldn't say, because I don't know
3 anything about their board process. And I
4 don't know when he received that extra
5 certification, which makes a difference,
6 because there may or may not have been a
7 formal process, and certification may be a --
8 having gone through a truncated process or it
9 may be a formal process. That entitlement
10 doesn't tell me the nature of his extra
11 training.

12 Q Okay. So, you are board certified
13 in anesthesiology?

14 A Yes.

15 Q And you have a subspecialty through
16 the anesthesiology board for pain management,
17 or is it pain medicine?

18 A Well, it depends on who you go to.
19 My boards in pain medicine are through the
20 American Academy of Pain Medicine, not
21 through the American Society of
22 Anesthesiology.

23 Q Okay. If you are a member of the
24 American Academy of Pain Medicine, does that
25 mean you're automatically certified through

1 some questions. Ryder sent medical records
2 to some other doctors -- they call them peer
3 reviews -- and asked them about some things,
4 including your treatment of Mr. Sasser.

5 One of them, specifically, was Terrance
6 Wilson, who is board certified in physical
7 medicine and rehabilitation, with a
8 subspecialty certification in pain management
9 -- or pain medicine. Is that the same board
10 certification you have?

11 A I don't know.

12 Q Your board certification is in
13 anesthesiology? Is that correct?

14 A Well, your question is a little
15 more complicated than you think.

16 Q Okay. Maybe you can explain it to
17 me.

18 A First of all, physical medicine and
19 rehab is an entirely different specialty from
20 anesthesiology. Basically -- well, it's a
21 specialty also known as physiatry. So, they
22 do physical modality, physical therapy,
23 occupational therapy. They're physicians.
24 They're not just physical therapists.
25 They're physicians. But, what his specialty

1 them?

2 A No. You have to take an
3 examination.

4 Q So, the membership is just
5 something you can do without being board
6 certified?

7 A Right.

8 Q Okay. So, the fact that this
9 Doctor is a member of the American Academy of
10 Pain Medicine doesn't give us any more
11 information regarding his certification in
12 pain medicine or not? Is that correct?

13 A That's correct, although -- not to
14 say that he didn't take the examination --

15 Q Sure.

16 A -- and pass it.

17 Q It doesn't help us one way or
18 another?

19 A No.

20 Q Is that fair?

21 A I mean, I'm a member of lots of
22 societies, which typically don't provide
23 certification, so --

24 Q All right. He specifically states
25 that he reviewed -- it says available medical

1 records. I'm not quite sure what was
2 available. But, initial record review
3 performed by this evaluator recorded in the
4 report of 3-17 of '03. Additional
5 documentation has been submitted for review.
6 Medical treatment provided during 2004
7 included bilateral trigger point injections
8 into the vastus lateralis muscles, performed
9 on 1-20 of '04. During the calendar year
10 2003, there was documentation of medical
11 encounters on 4-9 of '03, 5-7 of '03, 6-24 of
12 '03, 7-18 of '03, 10-28-03, 12-29-03.
13 Trigger point injections were performed into
14 the left peroneus longus muscle on 10-28-03
15 and 12-29-03. Is that your treatment?

16 A Yes.

17 Q Okay. So, he's basically saying he
18 has reviewed your treatment records?

19 MR. KNOTT: Object to the form.

20 A Right.

21 Q Is that correct?

22 MR. KNOTT: Object to the form.

23 Q At least based on what he states
24 here, those dates would correlate with your
25 treatment?

1 A Those dates correlate with my
2 treatment.

3 Q And the trigger point injections
4 were things performed by you here in your
5 office --

6 A Yes.

7 Q -- or at the clinic?

8 A Except -- I'll just take issue with
9 the 12-29. That was a follow-up visit. My
10 records don't reflect trigger point
11 injections being done at that time. That's
12 nitpicking, but --

13 Q Well, no. I mean, he's basing his
14 opinion on saying that those trigger point
15 injections were performed on those he listed
16 in this record. You're taking issue that you
17 did not do a trigger point injection on
18 12-29-03?

19 A Right, but -- yes.

20 Q Now, he states, "Based on his
21 review of the available records, it is my
22 professional medical opinion that none of the
23 treatment documented during 2003 and 2004 is
24 causally related to the work injury of 9-8 of
25 '95."

1 Now, in your opinion, was the treatment
2 you provided to him, as documented in those
3 treatment records, a necessary treatment to
4 treat the back injury he came in here from
5 Dr. McGahan for?

6 MR. KNOTT: Object to the form and
7 hypothetical.

8 A Yes.

9 Q Do you disagree, then, with his
10 assessment -- if, in fact, the injury on 9-8
11 of '95 was the low back injury that
12 Dr. McGahan was treating him for, do you
13 disagree with that assessment and that
14 opinion of this man?

15 MR. KNOTT: Object to the form and
16 predicate and hypothetical.

17 A Yes.

18 Q As a physician, do you prefer to
19 see a patient and actually examine that
20 patient and follow that patient in order to
21 offer an opinion about that patient's
22 condition, versus reading records from other
23 doctors?

24 A Yes.

25 Q Which one, in your opinion, as a

1 physician, is more helpful to making an
2 accurate assessment of a patient?

3 A Direct contact with the patient.

4 Q Okay. And you had had direct
5 contact with this patient from September of
6 2000 all the way through May of 2004?

7 A Yes.

8 Q Okay. I have another opinion they
9 submitted from William Cabot, a diplomate of
10 American Board of Orthopedic Surgery, fellow
11 of the American Academy of Disability
12 Evaluating Physicians. And it says,
13 apparently, he's president of that. That
14 physician, is he board certified, based on
15 this record, in any area that you're board
16 certified in?

17 A No.

18 Q In his opinion, he thought that Mr.
19 Sasser needed epidural blocks --

20 MR. KNOTT: Excuse me, Amy. What
21 date record are you looking at?

22 MS. SHUMATE: I'm looking at the
23 letter that you attached to
24 your summary judgment motion
25 dated May 15th, 2002.

MR. KNOTT: Is that something in his file or is it --

MS. SHUMATE: No. It's something outside -- it's what you presented to the court. I'm just going to ask him questions about it.

MR. KNOTT: Well, I know you and Bill have had some communications about the deposition. Bill had raised some concerns about expert designation.

MS. SHUMATE: Sure.

MR. KNOTT: And you had indicated that you were just taking his deposition as a treating physician.

MS. SHUMATE: I am.

MR. KNOTT: So, I think the scope of this deposition should be based on his treatment and his opinions concerning --

MS. SHUMATE: And I agree.

MR. KNOTT: -- his treatment and

he's not been designated for that purpose.

MS. SHUMATE: Okay. And your objection is noted on the record, and I appreciate it. I am certainly going to ask him questions, if there's another physician who has disagreed with his treatment regimen, whether he feels his treatment regimen was, in fact, necessary. And I'm going to ask him that, and he can answer those regarding a treating physician, without being hired as an expert. So, your objection is on the record.

Q Now, this Dr. Cabot, when he gets to the discussion of your treatment, basically he felt the nondermatomal numbness that you mentioned, the nondermatomal pattern, was significant, because -- I guess, to him, that would be significant.

Did you find anything about that particular note you entered on 9-5, about him

the conditions. And I think if we go outside of that and start having him comment on other opinions of other people that were not involved in Dr. Marsella's course of treatment and with his discussions with other -- or communications with other physicians about the conditions, then I think we're kind of going outside his role as a treating physician, and I think we would be putting Dr. Marsella more in the place of being a regular sort of court expert as opposed to a treating physician. And so, I think we need to -- so, we're going to object --

MS. SHUMATE: Okay.

MR. KNOTT: -- to the extent that this line of questioning is going beyond his regular role as a treating physician, and

having nondermatomal pain or numbness, that made you feel like he was not being truthful or honest with you?

MR. KNOTT: Object to the form and the predicate.

A No.

Q Do you believe anti-inflammatory medication, rather than the narcotic medication you were providing to Mr. Sasser, would have been appropriate in this case?

A Are you asking instead of or in addition to?

Q No. Instead of. Do you think that would have helped him, given what you saw him with for four years?

A I think it would have been inadequate.

Q Inadequate. And is that based on your observation of the way he did respond to narcotic medication from September of 2000 to May of 2004?

A Yes.

Q Do you believe an epidural block would have been more helpful than the treatment you gave him for the treatment of

1 his spinal stenosis?

2 MR. KNOTT: Object to the form and
3 the predicate.

4 A I have a little hand comment,
5 handwritten comment, on the follow-up visit
6 note of 1-20-03, in which I have said, the
7 patient had five to six LES, or lumbar
8 epidural steroid injections, without benefit.
9 That being the case, on that date, from
10 1-20-03, from that point onward, I would have
11 seen little benefit to do more of those.

12 Q Okay. He also makes the statement
13 that narcotics for degenerative disc disease
14 typically take a patient down a road which
15 does not have a good outcome. Would you make
16 that assessment in Mr. Sasser's case? Would
17 you agree with that statement in Mr. Sasser's
18 particular case?

19 A Well, since I don't know what that
20 statement means, I can't say.

21 Q In your opinion, for your treatment
22 for Mr. Sasser, based on your hands-on exams
23 and evaluations of him throughout that
24 four-year period of time, did you believe
25 that the medication and trigger point

1 pain would be significantly worse than what
2 you had got it regulated to?

3 MR. KNOTT: Object to the form and
4 the predicate.

5 A Well, I couldn't say. All I can
6 say is that, with the medication and the
7 treatments that I provided, Mr. Sasser wasn't
8 cured, wasn't 100 percent better, was not
9 pain free, but seemed to me to be at least
10 able to function and maintain some -- have
11 some quality of life that he may not have
12 been able to enjoy without the medication and
13 treatments.

14 Q Did he have a higher level of
15 functioning, physical functioning, while he
16 was taking the medication and having the
17 injections, meaning he could do more things,
18 he could be more active, because pain wasn't
19 as limiting?

20 MR. KNOTT: Object to the form and
21 the predicate.

22 A I don't have any objective
23 information in that regard.

24 Q Would that be what you would
25 anticipate in his condition?

1 injections were the best, most conservative
2 treatment for his pain?

3 MR. KNOTT: Object to the form.

4 A Yes.

5 Q And were those treatments of the
6 medication and the trigger point injections,
7 in your opinion, a medical necessity to treat
8 the pain he suffered in his lower back?

9 MR. KNOTT: Object to the form and
10 the predicate.

11 A Well, again, you know, I understand
12 the legal point of medical necessity. There
13 aren't very many things in life that are
14 necessary. It's certainly medically
15 appropriate. I don't like that "medically
16 necessary" term, personally.

17 Q Sure. You understand, legally,
18 that is the term --

19 A I think it was appropriate
20 treatment for his problem. In that sense,
21 medically necessary, if that's how that term
22 is used.

23 Q And without that medication and
24 trigger point injections, and, thus, with no
25 other treatment, would you expect that his

1 A You know, typically, pain scores,
2 which we sometimes relate and sometimes
3 don't, were on a scale of ten. Zero, no
4 pain. Ten, great pain. His typical pain
5 scores were five, six, seven, in sort of the
6 middle range. So, in our patient population,
7 that usually implies reasonable pain relief.

8 Q And I'm going to ask you this based
9 on your experience with Mr. Sasser and with
10 other patients who have similar-type
11 conditions.

12 If he was not able to take the
13 medication because the company either
14 wouldn't pay for it or he had no financial
15 resources, whatever, and he was suddenly
16 taken off that medication and no longer
17 allowed to have medical treatment, including
18 any pain management at all, would you
19 anticipate that, based on your four years
20 with him, that his pain complaints would go
21 up?

22 MR. KNOTT: Object to the form and
23 the predicate.

24 A Yes. I would expect that, yes.

25 Q You would expect that. That would

1 be something that, based on your treatment of
2 him, you would expect that to happen to him,
3 if he were not able to have pain management?

4 MR. KNOTT: Object to the form and
5 the predicate.

6 A Yes.

7 Q Is that correct?

8 MR. KNOTT: Object.

9 A That's correct.

10 Q I mean, the whole point of your job
11 for him is to help reduce his pain? Correct?

12 MR. KNOTT: Object to the leading.

13 A Part, yes. One of the things. I
14 mean --

15 Q What else would it be?

16 A Well, typically, we reduce pain,
17 reduce the subjective symptoms of pain,
18 improve quality of life, and improve
19 function.

20 Q Okay. The medication that he was
21 taking, the Oxycontin and things like that,
22 do they have side effects that would affect
23 him when he's taking them?

24 A They have side effects that could
25 affect anybody.

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1 Q Such as?

2 A Well, the typical ones are itching,
3 nausea, vomiting, constipation, urinary
4 retention. At higher doses, respiratory
5 depression or arrest. Typically, that's at
6 toxic doses. Those are sort of the -- well,
7 sedation, confusion, mental status changes.

8 Q Okay. Is that something -- someone
9 who, certainly, like Mr. Sasser, who had been
10 taking this medication for years, is that the
11 type of confusion, sedation -- does that mean
12 sleepiness, things of that nature --

13 A Yes.

14 Q -- that he would experience?

15 A Possibly.

16 Q The level of pain he was
17 subjectively reporting to you, as well as the
18 medication regimen he was on, would that
19 interfere with his ability to hold down a
20 40-hour-a-week job, in your opinion?

21 A I can't say.

22 Q Do you find a lot of your patients
23 who come in with his level of pain and the
24 four years of pain management to be -- a lot
25 of them are in the disabled category,

1 workwise?

2 MR. KNOTT: Object to the form and
3 the predicate.

4 A I can't say that.

5 Q Okay. Was there anything about him
6 that made you feel like he was faking? I
7 mean, no better word a jury will understand
8 than the word "faking." Is there anything in
9 his presentation to you or in his tests that
10 made you feel like the man was faking his
11 problems?

12 A No.

13 Q Would it be fair to say you would
14 not have continued him on this narcotic
15 regimen had you felt that?

16 A That's correct.

17 Q As his treating physician as of May
18 of '04, do you have an opinion as to whether,
19 at that time, he should have continued with
20 pain management?

21 A My opinion is that he should have.

22 Q Okay. And would that be to a
23 reasonable degree of medical certainty that
24 that pain management treatment would have
25 continued to be necessary for his back pain?

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1 A Yes.

2 Q Now, did you have any discussions,
3 or did, to your knowledge, your office have
4 any discussions with Ryder or Intracorp
5 regarding their cutting him off?

6 A Not that I know of.

7 Q Were you told about appeal
8 processes or that you, as a physician, were
9 supposed to do something to get him reinstated
10 or anything along that line?

11 A Well, the only -- you referred
12 earlier to a communication of 7-12-04.

13 Q Yes.

14 A In my record here in front of me,
15 that is the only communication that I
16 received.

17 Q And was that indicating to you that
18 they weren't going to ever let him come back,
19 or just they weren't going to approve that
20 particular request for treatment?

21 A You know, I really don't know the
22 answer to that question. It only says that
23 -- they refer to specific dates of treatment.
24 And it just sort of generically says that I
25 can receive -- the treating physician may

1 receive a copy of the guidelines used in the
2 review. If I have additional clinical
3 information, et cetera, et cetera, that I
4 have the capability of appealing, and tells
5 me to whom to appeal.

6 Q And did you follow up with any
7 appeal or send any additional records to
8 them, to your knowledge?

9 A Not to my knowledge.

10 Q Did you send any further requests
11 for treatment for Mr. Sasser to Intracorp
12 that were denied?

13 A Not to my knowledge.

14 Q Did you send any further requests,
15 whether they were denied or not?

16 A I don't think so.

17 Q Okay. Do you have any independent
18 recollection, outside of what's in your
19 chart, that deals with this issue of them
20 having cut him off?

21 A About what?

22 Q About whether Intracorp was going
23 to continue to pay for him or anything.

24 A I have no idea.

25 Q If, in fact, Ryder -- I have a

1 information from Intracorp or Ryder that that
2 was the case? That he had been cut off
3 totally?

4 MR. KNOTT: Object to the form and
5 the predicate.

6 A I don't have that letter in my
7 chart here.

8 Q To your knowledge, did you receive
9 any information from them as to the need for
10 precertifications?

11 A Typically, that doesn't come to me.

12 Q If, in fact, you had received that,
13 would you have done the procedures necessary,
14 to your knowledge, or your office staff would
15 have done the procedures necessary to see
16 that Mr. Sasser continued to get his
17 treatment?

18 A Typically, yes.

19 Q And based on what I've talked to
20 you about Dr. Cabot and Dr. Wilson's opinions
21 regarding your treatment, do you disagree
22 with their opinions regarding your treatment?

23 MR. KNOTT: Object to the form and
24 the predicate.

25 A Well, I never really heard Dr.

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1 letter dated June 17th, 2004, that the
2 defendant submitted for his summary -- excuse
3 me -- that I had in my file from Ryder -- or
4 Intracorp. Excuse me. No. It's from Ryder
5 -- that says, to Dr. McGahan, to
6 Dr. Marsella, to Clio Pharmacy. "As the
7 adjustor for this workers' compensation case,
8 I am currently notifying you that, effective
9 immediately, any and all medical services,
10 procedures and prescriptions provided to this
11 patient must go through the workers'
12 compensation precertification process." Did
13 you receive that letter from Marty Lloyd?

14 A Well --

15 Q Would that be something you would
16 keep in this chart versus the Medical Center
17 chart?

18 A That would be something that I
19 would have in this chart, and I don't have it
20 here.

21 Q Okay. And if it states that no
22 further action or precertification was ever
23 requested, therefore, Mr. Sasser's med
24 treatment/coverage under workers' comp was
25 denied effective 6-17-04, were you given any

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1 Cabot's opinion. I'm sorry. I think we
2 got --

3 Q We went off on some of the
4 treatments. He would have said the opinion
5 regarding needing anti-inflammatories --

6 A Oh, yes.

7 Q -- the need for epidurals, and the
8 need that narcotic medication is not
9 necessarily a good outcome. Those opinions.
10 Do you disagree with those two doctors'
11 assessments of this particular man's case?

12 MR. KNOTT: I'll object to the form
13 and the predicate. And I'll
14 point out that Dr. Marsella
15 has, I believe, not even
16 reviewed the whole --

17 MS. SHUMATE: I understand.

18 MR. KNOTT: -- written opinion of
19 Dr. Cabot, and that what he's
20 being asked to comment on now
21 are the pieces of the letter
22 that have been quoted or
23 summarized by plaintiff's
24 counsel.

25 MS. SHUMATE: I'm sorry. Did we

1 have usual stipulations on this
 2 deposition, that all other
 3 objections besides form of the
 4 question will be reserved for
 5 trial?
 6 COURT REPORTER: None were stated.
 7 MS. SHUMATE: Do we have usual
 8 stipulations, or do we need to
 9 go back over this?
 10 MR. KNOTT: We have the usual
 11 stipulations.
 12 MS. SHUMATE: Thank you.
 13 Q You can answer the question,
 14 despite his objection.
 15 A Well, I think we already addressed
 16 the first -- not Dr. Cabot, but the other
 17 opinion. As far as Dr. Cabot's opinion, I
 18 guess we did discuss that.
 19 No, I don't think nonsteroidal
 20 anti-inflammatories by themselves would have
 21 been adequate.
 22 No, I don't think that epidurals would
 23 have been appropriate, because, as I
 24 mentioned earlier, back in January of --
 25 whenever it was. 1-20-04, I think it was. I

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1 think that was the date -- that Mr. Sasser
 2 told me -- yeah. 1-20-03. I'm sorry -- Mr.
 3 Sasser had said he had had five or six
 4 epidurals without benefit. And I didn't see
 5 any point in continuing with that.
 6 The third thing about the -- I don't
 7 want to say he's saying probable, but
 8 possible poor outcome with the continued
 9 opioid use is true in anybody's case.
 10 In Mr. Sasser's case, he was complying
 11 on his medication regimen, as evidenced by
 12 the fact that he never, in my opinion,
 13 requested overages of his medication or early
 14 refills, and by urine drug screen, was always
 15 compliant and within the parameters for the
 16 use of those medications that I prescribed
 17 for him.
 18 Q And would those drug screens have
 19 shown if he were overmedicating?
 20 A Yes.
 21 Q And that was not a concern
 22 throughout all those urine tests that your
 23 office performed?
 24 A That's correct.
 25 Q Okay. The use of those particular

1 medications he was on, would they give
 2 someone the slurred speech at times, or seem
 3 drowsy and things of that nature, to someone
 4 who maybe doesn't know what they're taking?
 5 A Theoretically?
 6 Q Uh-huh.
 7 A Yes.
 8 Q Okay. So, if there were times when
 9 someone might notice if he had slurred speech
 10 or seemed drowsy or sleepy, that would not
 11 give you great concern, given you knew he was
 12 compliant with his medication? Is that fair
 13 to say?
 14 A There are a lot of reasons for
 15 people to slur their speech and be sleepy.
 16 If you stay up for three days in a row, it
 17 will do that to you. So, I wouldn't say that
 18 slurred speech and sedation, sleepiness, are
 19 necessarily indicative of overuse of
 20 anything, any substance.
 21 Q And you specifically tested him
 22 regularly and routinely, through the urine
 23 drug screens, to make sure there was no
 24 overmedicating going on? Is that correct?
 25 A That was the intent.

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1 Q And that's what you do for your
 2 patients who take narcotics like this, to
 3 make sure they're not overmedicating
 4 themselves -- is that correct? -- or getting
 5 medication from sources other than what you
 6 give them?
 7 A In general terms, we use the
 8 screens to determine compliance.
 9 Q That they're taking it, and they're
 10 not selling it somewhere, and that they're
 11 not taking too much?
 12 A Right. And that what is being
 13 prescribed is what's being taken, and what is
 14 being found has been prescribed.
 15 Q If he had been determined by --
 16 hold on a second. I'm sorry.
 17 MS. SHUMATE: I'll tell you what.
 18 I'll probably save that for
 19 rebuttal, because I'm sure
 20 something will come up about
 21 it. So, that will be all the
 22 questions I have.
 23 I would ask that your
 24 convenience chart that you've
 25 testified from today be copied

and attached in its entirety as
Plaintiff's Exhibit No. 3.
That way, we'll have a clear
picture of what you had versus
what the Medical Center had, if
that's all right.

DR. MARSELLA: Fine with me.

MS. SHUMATE: All right. And
that's all the questions I
have. If you would certainly
answer Mr. Knott's.

EXAMINATION

BY MR. KNOTT:

Q Hi, Dr. Marsella. My name is
Conley Knott, and I represent Ryder in this
case. And I have a few questions to ask you
about the course of your treatment and some
of your opinions.

Amy has already covered a lot of the
course of treatment, so, hopefully, we'll be
biting off smaller and smaller chunks as we
go, as we put a finer point on things. And
also, for that reason, I might seem like I'm

you about what happened to him to cause his
pain, is that the only thing that you, as a
treating physician, have relied on in terms
of your opinions concerning what caused him
to have the pain?

A Yes.

Q Now, I want to ask you a little bit
about one of the terms in your office notes
that you testified to a little while ago, a
nonradicular pattern. A nonradicular pattern
is what you found with Mr. Sasser? Is that
right?

A Yes.

Q You explained something about how
that relates to a nerve root. Could you
explain that?

A Certainly. There are nerve roots
that come off of the spinal cord. Imagine,
if you will, a large taproot, underground,
and off of that come smaller roots. Well,
the large taproot would be comparable to the
spinal cord, which comes off of the brain.

Smaller nerves come off of that, which
we call the nerve roots. And each of those
-- there's one on each side of the body at

jumping around a bit, because there's no
point in starting at the very beginning,
chronologically.

But, that being said, I do kind of want
to start at the beginning of your treatment
in 2000, and ask you -- and it was the year
2000 that you first saw him, or was it 2002?

A No. It was 2000. September the
5th of 2000 was my initial visit date.

Q And there was some discussion about
the information that you, as a treating
physician, have had with regard to the
original causative event that might have led
to the conditions and the complaints that Mr.
Sasser came here for, specifically, just for
the layperson's parlance, what it was that
made him have the back pain, what happened to
him.

Is it your testimony that you have been
relying on the patient's own reports of what
happened to him to cause his pain?

A That's true.

MS. SHUMATE: Object to the form of
the question.

Q Is the patient's verbal report to

various levels, from the top of the spine all
the way down to the bottom of the spine.
These nerve roots exit the spine, and then,
go to parts of the body, depending on where
they come off. Each of those nerve roots
then gives off smaller nerves, which give off
smaller nerves, eventually going to the end
of the line.

Typically, each nerve root serves a
certain part of the body, and historically
have been mapped out in what have been called
dermatomes. Now, obviously, everybody is
different. And so, a dermatome in one person
for a particular nerve root would be
different, to an extent, than another person.
But, in general, we rely on these maps to
give us an idea about what nerve root may be
involved.

Sometimes there's crossover between
dermatomes, as you get further out, so that,
sometimes, the picture is not quite as
distinct. And so, a nonradicular -- the term
"nonradicular" is only meant to imply that it
doesn't strictly follow the course of a
dermatome or a nerve root map, if you will.

1 Q Okay. Now, in a patient where the
2 complaints of pain do follow that roadmap, is
3 that what you would call a radicular pattern?

4 A Right, if it's consistent with what
5 we know as the dermatomes.

6 Q And when you find a radicular
7 pattern in a patient, are you able to
8 conclusively relate that complaints of pain
9 to some sort of condition with the spine?

10 A In many cases, yes.

11 Q When there's a nonradicular pain,
12 when the complaints of pain don't follow that
13 classic roadmap, is there less certainty to
14 where in the body the pain is originating?

15 A Yes.

16 Q And so, it's not necessarily, in
17 those cases, related to a back problem
18 specifically? It could be a number of other
19 things?

20 A Well, if we think back about the
21 fact that, you know, the body is a very
22 complicated machine, the nerves aren't the
23 same in everybody. And so, while there may
24 be problems in the back causing problems with
25 more than one nerve root, as you get further

1 maybe being related, maybe not, to complaints
2 of leg pain, are there tests, like, radiology
3 tests, that a doctor can use to determine
4 that?

5 A There are several things.
6 Certainly MRIs, magnetic resonance imaging
7 scans, can be used to see if there is a
8 presence or absence of a herniated disc or a
9 bone spur or anything like that.

10 There are tests that can be done to
11 check the integrity of the nerves and the
12 muscles that those nerves serve,
13 electromyograms and nerve conduction velocity
14 studies.

15 Q Electromyogram, is that what they
16 call an EMG sometimes?

17 A EMG. EMG and NCV, nerve conduction
18 velocity studies.

19 Q I didn't see in your records
20 whether or not you had performed any of those
21 tests --

22 A Did not.

23 Q -- an MRI or --

24 A Did not. And I didn't have access
25 to any records that reflected whether he had

1 out towards the end of the line, the
2 distinction becomes blurry -- may become
3 blurry. Whether it will or not, no one can
4 say. But it may become blurry to the point
5 that it's difficult to say exactly where the
6 pain is originating.

7 But, in general terms, if there is, in
8 this case, lower extremity pain, well, the
9 lower extremities, the legs, receive their
10 innervation from the lower part of the spine,
11 in the lumbar area.

12 Now, the nerves come off of the spinal
13 cord higher up, but they exit the spine in
14 the lumbar area, so that if there's a problem
15 in the lumbar spine causing an issue with a
16 nerve root as it exits the spine, while it
17 may be difficult to say specifically which
18 nerve roots are involved, in general terms,
19 you can say that leg pain may certainly be
20 related to back pain, and would more
21 particularly be related to low back pain -- a
22 low back problem. Not pain, but problem.

23 Q When we get to that point where --
24 in terms of attempting to isolate nerves in
25 the back and the branches off the spine as

1 had those done.

2 Q Do you know whether or not he had
3 had those done? Have you heard?

4 A I don't know.

5 Q If he had had those done, or if he
6 does have those done, particularly in a
7 patient who has nonradicular complaints of
8 pain, would that be the best evidence for
9 you, as a physician, to look at, in terms of
10 determining whether or not complaints of leg
11 pain are related to the problem with the
12 back?

13 A Well, it's not really a
14 straightforward answer. Possibly -- it will
15 be the best answer I can give you. The
16 purpose of those types of studies,
17 specifically the EMG/NCV, is to determine the
18 normalcy or abnormalcy of a particular nerve
19 root at a particular level in the spine or
20 more peripheral nerves, and the effect that
21 those nerves have, if any, on the muscles
22 that they're serving, if there's any -- what
23 the normalcy or abnormalcy of that response
24 is.

25 Certain assumptions are made that, if

1 there is, say, a disc or a spur in the part
2 of the spine where that particular nerve
3 exits that's being tested, and there's a
4 problem with the nerve, that they are
5 related. One would assume that.

6 Q As a physician, when you have
7 access to studies like that, like an MRI that
8 you were talking about, when you have access
9 to studies like that to review, when asked to
10 state an opinion about the cause of a
11 particular problem or complaint, does that
12 put you in a position to state your opinion
13 with more certainty?

14 A Well, in a sense, if the question
15 is, with someone who presents with left leg
16 pain, and an MRI shows a protruding or
17 bulging or herniated disc in the lower part
18 of the back, in the lumbar spine, that pokes
19 out more on the left side at a particular
20 level, and seems to pinch or impinge on a
21 particular nerve root, then I would be able
22 to -- in my mind, to my best medical
23 judgment, would say that, assuming that the
24 leg pain that we're talking about follows the
25 distribution of that particular nerve root,

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1 and the fact that the nerve root is being
2 pinched by whatever it is that's pinching it,
3 that those two are related.

4 However, it would be impossible to say
5 what the cause of the spinal problem is. In
6 other words, where did the disc come from?
7 Where did the spur come from? It would be
8 impossible to say that.

9 Q In terms of connecting it to a
10 particular event?

11 A Event. Yes.

12 Q Okay. Now, other than, say -- you
13 talked about, I think -- you used the word, I
14 think, herniation or disc bulge or a pinching
15 a nerve.

16 A Right.

17 Q I think these are terms that have
18 come up. Other than that particular, you
19 know, mechanism in the body, are there other
20 things that can cause a person to have pain
21 similar to the complaints that Mr. Sasser
22 reported to you?

23 A Uh-huh.

24 Q What are some of the other things
25 that can cause that, in terms of, you know,

1 bodily conditions?

2 A As far as back pain, there are a
3 lot of things in the back. There are
4 muscles. They can hurt. There are joints in
5 the spine. They can cause pain. The discs
6 themselves can cause pain. The effect of a
7 bulging disc or an overgrown joint capsule or
8 degenerated disc, any of these things can
9 cause problems with nerves, which can cause
10 pain. So, there are a lot of things that can
11 cause back pain and leg pain.

12 Q Now, he didn't just report pain to
13 you. Did he also report numbness or a loss
14 of sensation in his legs?

15 A On exam, as you referred, there
16 was, in our report, the nondermatomal
17 decreased sensation to light touch.

18 Q Now, your records, I believe, also
19 reflect a number of other health problems
20 that Mr. Sasser has had treatment for. And I
21 guess the best place to -- since you're
22 looking back at your records -- to turn to,
23 might be your initial office note.

24 A Right.

25 Q Could you summarize some of those

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1 conditions that he reported to you as also
2 having?

3 A Occasional angina, which is
4 heart-related chest pain. Angina on
5 exertion. Occasionally mild at rest.
6 Congestive heart failure. He reported having
7 had a heart attack or a myocardial infarction
8 in 1996. In 1998, he had a coronary artery
9 bypass graft operation, and, according to
10 him, apparently had a valve problem, but I
11 don't know the nature of that. He didn't
12 have any valve surgery. He also reported
13 decreased renal function, or kidney function,
14 as a result of his high blood pressure.

15 Q Okay. Do you know the mechanism of
16 how that works? How you could have renal
17 problems, kidney problems, resulting from
18 high blood pressure?

19 A Sure.

20 Q What is that? How are those
21 connected?

22 A Well, any part of the body that
23 doesn't receive adequate blood supply, the
24 cells don't do well. They don't function
25 normal. And that's, you know, renal

1 insufficiency, hepatic insufficiency,
2 whatever part of the body.

3 Q Are kidney problems sometimes
4 related to numbness in the extremities?

5 A Well, not being a nephrologist -- I
6 suspect, in their literature, one might find
7 that. But I don't focus on that, so I can't
8 answer that question. I wouldn't take my
9 answer as being an expert medical opinion on
10 that issue.

11 Q Fair enough. How about the
12 congestive heart failure? Are you in a
13 position to state an opinion with regard to
14 that?

15 A Well, congestive heart failure can
16 lead to swelling of the extremities as a
17 result of fluid buildup, fluid retention,
18 which can be painful. But those, typically,
19 are more distal towards the feet and ankles,
20 lower part of the legs, can come all the way
21 up the thigh. But that would be -- if there
22 was enough edema to cause pain, it would be
23 obvious that there was significant edema.
24 Plus, the typical complaint of the nature of
25 the pain is different than it is with pain as

1 entity, dates back to the end of the Second
2 World War. However, as a medical
3 subspecialty, as a medical specialty
4 subspecialty, it has really come into its own
5 in the last 20 to 25 years.

6 Q Are there objective medical
7 findings that physicians can use to determine
8 whether or not pain exists or not or where
9 the pain is? With a broken bone, we can use
10 an X-ray. With a nerve, we can use an MRI.
11 Is there anything like that in the pain
12 management field?

13 A No, not today.

14 Q And that puts you, as a physician,
15 in a little bit of a different position,
16 then, as opposed to an orthopedic surgeon,
17 for example, in terms of what you have
18 available to you in order to diagnose and
19 treat a condition?

20 A In a sense.

21 Q Is pain management successful in
22 100 percent of your patients?

23 A No.

24 Q I'm not going to ask you to put a
25 statistical figure on it, unless you happen

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1 a result of a back.

2 Q Can diabetes also be related to
3 numbness in the extremities?

4 A Uh-huh.

5 Q Is that a "yes"?

6 A Yes.

7 Q We're taking it down on paper.

8 A Yes. You didn't hear the rattle,
9 my head shaking?

10 Q I got it. I don't know if the
11 court reporter did. Do you know whether or
12 not Mr. Sasser has ever been tested for
13 diabetes?

14 A I don't know that.

15 Q Is diabetes, to your knowledge,
16 often related to renal insufficiency?

17 A Can be. But what the statistical
18 correlation is, I can't say.

19 Q Is pain management a relatively new
20 field when you compare it to other medical
21 specialties out there? Or how long has it
22 been around? Rather than asking you -- we
23 can put an objective point on it. How long
24 has the board been around?

25 A The concept of chronic pain, as an

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1 to have that in your head. But there are
2 some patients who simply don't respond to the
3 modalities and the treatments that you have
4 available. Is that a fair statement?

5 A That's fair.

6 Q And that can be for a number of
7 reasons? Would that be --

8 A That's fair to say.

9 Q Have you had patients that you've
10 treated where you concluded that pain
11 management was not getting them anywhere?

12 A I have.

13 Q Okay. And how long would you treat
14 those patients before you made that
15 determination, before you felt comfortable
16 with the fact that we're getting nowhere?

17 A I can't say.

18 Q Okay. Is there a range that you
19 think would be -- a minimum that you would
20 want to stick with a patient and work on
21 different treatments before you drew that
22 conclusion?

23 A I can't say.

24 Q In order to reach that conclusion
25 that the pain management was not helping,

1 would you rely mostly on the patient pain
2 scores, or what would you rely on?
3 A A number of things. First of all,
4 in order for me, personally, to reach that
5 sort of opinion, I would have to feel
6 comfortable and confident that I have tried
7 everything that I know how to do for a
8 particular pain problem, regardless of what
9 those modalities included, and that the
10 patient has not responded.

11 And by that, I mean, referring back to
12 sort of the triumvirate of our goal, that
13 being, reduce pain, subjective complaints of
14 pain, improve function, and improve quality
15 of life. If the patient can't give me
16 feedback to make me believe that any of those
17 have been achieved, then I would have to say
18 that pain management has not been successful
19 in a given patient.

20 How long that takes -- it may take two
21 months. It may take two years. Sometimes it
22 takes a long time to go through the whole
23 gamut of possible treatments. So, it's just
24 not -- and sometimes it takes even longer
25 than two years.

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1 Let me also say that we don't ever
2 expect to get somebody pain free. It would
3 be nice to hope that that would happen, but
4 we don't expect it. We hopefully get the
5 patients to understand that we don't expect
6 that. Because, sometimes, they come to us
7 expecting that. And in someone who never
8 gives up that belief, that's a person that
9 would have a difficult time getting any
10 benefit from what we have to offer. We don't
11 have many of those. Most people are pretty
12 realistic about what they expect to get out
13 of what we have to offer.

14 And there are patients that we see, that
15 I've seen for years and years and years, who
16 are no better than they were to start with,
17 in a sense. In other words, their complaints
18 of pain continue, but they're certainly no
19 worse, and they continue to function, they
20 continue to be able to be involved in family
21 life, work, in some cases, enjoy recreation,
22 those sorts of things. I consider that to be
23 a successful outcome.

24 Q Do you consider counseling or
25 psychological or psychiatric treatment to be

1 a useful component in a pain management
2 program?

3 A Yes.

4 Q And do y'all employ that or do you
5 have a referral system --

6 A We do.

7 Q -- or something like that?

8 A We do.

9 Q Do you do that with all of your
10 patients, or with some, or how does that --

11 A Some, not all.

12 Q Based on your records, can you
13 determine whether or not counseling or
14 psychological or psychiatric services were
15 recommended or employed in the course of your
16 treatment with regard to Mr. Sasser?

17 A Part of our workup for our new
18 patients involves what's called an MMPI, or
19 Minnesota Multiphasic Personality Inventory.
20 We use a particular psychologist here in
21 town, primarily because he enjoys working
22 with chronic pain patients.

23 I have, in Mr. Sasser's record here, an
24 MMPI form and a request for an appointment.
25 However, I, unfortunately, don't have the

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1 results of that.

2 Q Do you have a date on the request?

3 A Well, I have a -- let's see. On
4 this particular -- this is a computer sheet
5 that has those little circles that are filled
6 in. The test date is 3-19-02. And it was
7 faxed on 3-20-02 and received on 3-20-02 from
8 Dr. Jacobs' office. But, unfortunately, I
9 don't have a result back on that.

10 Q Does the lack of having a result
11 back on that, does that tell you, one way or
12 the other, whether or not that was followed
13 up with or whether or not the evaluation took
14 place or anything else, or is it just an open
15 question?

16 A It's an open question. Let me also
17 say that, just by way of expounding on that,
18 that our request for the MMPI doesn't imply
19 in any way that we think that there is
20 psychological motivations in a patient's
21 request for our services. It's just part of
22 what we do.

23 Just also let me say that chronic pain
24 is a very complicated issue. There's
25 certainly the physical component, which, in

1 many cases, is the genesis of all -- the
2 whole picture. But chronic pain also has an
3 affect on a lot of aspects of a patient's
4 life which can't be objectified. It's
5 strictly subjective. And all of those
6 things, regardless of what they are, have an
7 impact on patients' abilities to function and
8 enjoy life, et cetera.

9 So, the MMPI really gives us some
10 insight into some those factors which may be
11 impacting the patient's ability to regain
12 function or enjoy life. It won't tell
13 anything about what kind of physical
14 modalities might help. It's not intended to
15 tell whether the patient is a malingerer.
16 That's not the point of it. That's not what
17 we use it for.

18 Q It's just an example of you trying
19 to treat the whole patient as opposed to just
20 putting a Band-Aid on it?

21 A Right.

22 Q Now, earlier, you testified --
23 well, actually, let's start back with looking
24 at your initial intake record from September
25 5, 2000. We've used the term "pain scale."

1 And I don't know if I was the one who used
2 that. You might have used it in your
3 testimony. But I want to make sure that the
4 jury is clear what that means, in terms of a
5 pain scale. What is that? Is that as a
6 diagnostic tool that you use in evaluating
7 patients?

8 A Well, it's not really a diagnostic
9 tool. Again, it's subjective.

10 Q Right.

11 A You alluded earlier to subjectivity
12 of pain. And it certainly is. It basically
13 is a ruler, so to speak, that allows us to
14 get a relative point of reference for a
15 particular patient.

16 Typically, when we describe the pain
17 scale to someone to help them tell us where
18 their pain is, we use a zero to ten. There
19 are others. But we use a zero to ten. Seems
20 to be the easiest one for everybody to grab
21 hold of.

22 And the way I describe it is that zero
23 is no pain, and ten is the worst pain that
24 you can ever imagine. And we can't say
25 specifically what that ten means, because

1 everyone's experience is different, and
2 everyone's -- and that's based on a lot of
3 different things. But, in general, everyone
4 can think of something in their life that was
5 the worst pain that they can recall, whether
6 it was childbirth, having your finger caught
7 in a door, whatever. Zero, most people can
8 relate to. Nothing.

9 So, what we ask the patient to do, then,
10 is to say where along that scale, zero, one,
11 two, three, four, et cetera, their pain is.
12 It gives us an idea of what they think their
13 pain is at that time. And it changes from
14 day to day. Changes from morning to
15 afternoon. It changes from one minute to the
16 next, sometimes. Where their pain is right
17 then. Because, tomorrow, it won't be the
18 same. It might, but it likely won't be. So,
19 even though it's a number, it's still
20 subjective.

21 Q Right. And zero on the scale, as a
22 physician, I guess you can assume is fairly
23 uniform across the board, from one patient to
24 the next?

25 A Well, I would say nothing is pretty

1 uniform.

2 Q But the ten, at the other end, is
3 something that's based on that patient's own
4 personal experience?

5 A Yes.

6 Q And you explain this pain scale to
7 the patients before they assign a number in
8 their initial office visit?

9 A Yes.

10 Q Explain it kind of the same way you
11 just did for the jury?

12 A I did.

13 Q On September 5, 2000, did Mr.
14 Sasser give you a number on his pain scale?

15 A He did.

16 Q And what was his number?

17 A His number, at that time, was a six
18 out of ten.

19 Q And I believe you testified that,
20 by 2004, he was in the range of five, six or
21 seven, which you characterized as the middle
22 range?

23 A Yes.

24 Q Is that also true?

25 A Uh-huh.

1 Q And that implies reasonable pain
2 relief?
3 A To me.
4 Q On September 5, at his initial
5 visit, was that information taken from Mr.
6 Sasser before any treatment was administered
7 by your office or after?
8 A Before.
9 Q I want to change gears a little bit
10 and ask you about this Intracorp letter that
11 I believe is one of the records in your file
12 in front of you. That letter that's dated
13 5-25, 2004.
14 MS. SHUMATE: I'm sorry. I thought
15 he said that was not contained
16 in his record. He has a July.
17 Q What's the date on the one in your
18 record, just so I'm clear? I don't want to
19 misstate it or act on a wrong assumption.
20 A 7-12-04.
21 Q Okay. And you were reading from
22 that earlier. And at the end of the letter,
23 you made a reference to some kind of appeal.
24 Could you read that out for me, so I can be
25 sure I have the language right?

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1 A It says -- this is the last
2 paragraph of page one. "If you have
3 additional clinical information which
4 documents the medical necessity of the
5 service, you may appeal this determination by
6 submitting a written request providing the
7 additional information. Please send the
8 appeal for request" -- and they give the
9 address.
10 Q Okay. And is it your understanding
11 that the letter indicated their opinion of a
12 lack of medical necessity for the treatment
13 that they were reviewing, for the proposed
14 treatment they were reviewing?
15 A Would you repeat that?
16 Q Is it your understanding from
17 reading the record that they concluded the
18 recommended treatment was not medically
19 necessary?
20 MS. SHUMATE: I object to the form
21 of the question.
22 A Well, I would assume that.
23 Q Let me ask you this way. You have
24 the letter in front you, and it's not a long
25 letter. What is your understanding regarding

1 their conclusions in that letter?
2 A Well, it's not -- the implication,
3 as I read it, is not that the treatments
4 aren't appropriate. It's just that -- and
5 I'll just quote. "It has been determined
6 that the medical information provided does
7 not support established standards of medical
8 necessity." I have no idea what their
9 guidelines are. So, what I take that to mean
10 is that they felt that the documentation was
11 inadequate, by their guidelines.
12 Q By their guidelines. And does it
13 make a reference --
14 A Not that he didn't need treatment
15 of some sort, but that, based on what
16 information they had provided and their
17 guidelines, that it didn't determine
18 suitability.
19 Q Right. Okay. And did that letter
20 say that your office could request a copy of
21 their guidelines?
22 A It does say that.
23 Q Okay. And the letter also says
24 your office could submit additional
25 documentation concerning the medical

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1 necessity --
2 A It does.
3 Q -- of the recommended treatment?
4 A It does say that.
5 Q Does anything in your file indicate
6 that your office made any communications or
7 sent any documentation to Intracorp following
8 that letter?
9 A There is nothing in my chart that
10 reflects that.
11 Q Has your office had to deal with
12 these type of peer reviews or these outside
13 review companies from time to time, just in
14 the course of the business end of your
15 practice?
16 A Yes.
17 Q And you, as the physician, are you
18 kind of the first point of contact with
19 regard to those companies, or do you have
20 office staff who sort of process that daily
21 paperwork?
22 A Well, the mail doesn't come
23 directly to me. But, typically, if there's a
24 request for further information or
25 notification of a peer review or whatever, I

1 eventually receive it. And it's up to me,
2 ultimately, to take it from that point on.

3 Q There is a, I guess, process, and
4 kind of a flow of the paperwork when it comes
5 in the office and comes to you? Is that
6 right?

7 A Yes.

8 Q And when all things work as
9 planned, all of the records come and are
10 presented to you? Is that right?

11 A Yes.

12 Q Aside from the way things are
13 supposed to work, do you have an independent
14 recollection of getting that particular
15 letter from Intracorp?

16 A This one?

17 Q That's right.

18 A Well, other than I see it here in
19 front of me, no.

20 Q You see it here in front of you
21 in --

22 A I don't recall the day it came to
23 my desk.

24 Q Right. You see it in front of you
25 in 2007. You don't remember having that

1 Q And when your office does that,
2 does your office sometimes get favorable
3 responses?

4 A I would assume. Basically, a
5 patient shows up, I work with the patient,
6 the patient goes home. What happens in
7 between all that, I usually don't know about.
8 I'm assuming, if they're here, everything
9 that's supposed to be approved is. I'm
10 assuming that, if they're here, they're here
11 for a legitimate reason.

12 Q Now, I believe one of your office
13 records indicates that Mr. Sasser received
14 several injections, all the way up until
15 2003. Were those lumbar steroid injections?

16 A No. The only injections that I
17 provided for Mr. Sasser were trigger point
18 injections in his legs, in various muscles of
19 the legs.

20 Q And when was the last series of
21 injections your office provided for him?

22 A 5-20-04.

23 Q 5-20-04.

24 A Uh-huh.

25 Q Do you have a record of anyone else

1 record brought to your attention in 2004 by
2 your office staff?

3 A Not specifically, no.

4 Q You would have preferred it to have
5 been brought to your attention? Is that
6 right?

7 A Well, it may have been.

8 Q And it's your understanding, since
9 it's in your record, that it did reach your
10 office?

11 A Obviously.

12 Q And would you have preferred your
13 office to have followed up with that letter
14 by requesting the guidelines from Intracorp
15 and/or submitting additional medical records
16 to Intracorp in order to address that letter?

17 A Typically, yes.

18 Q Is that something that your office
19 does from time to time with patients when
20 there's a letter from a payer questioning the
21 need for a service? Does your office
22 sometimes forward additional information to
23 that payer in order to justify your opinion
24 and your recommendations?

25 A Sometimes.

1 providing lumbar steroid injections?

2 A I don't have records. But Mr.
3 Sasser, in my note of 1-20-03 -- let me make
4 sure I have given you the correct date. But
5 I believe that's right. Yeah. I had already
6 referred to this earlier.

7 1-20-03, I had made a comment that the
8 patient had had five to six lumbar epidural
9 steroid injections without benefit. But I
10 don't have any records where he had them
11 done. This is simply a report by Mr. Sasser.

12 Q I see. Do you have any outstanding
13 bills for treatment of Mr. Sasser? Bills
14 that haven't been paid?

15 A I don't have any idea. I try not
16 to get involved with that.

17 MR. KNOTT: I may have some
18 additional questions after Amy.
19 She indicated earlier that she
20 already knew she had some
21 rebuttals before I even started
22 asking. So, I'll let her take
23 over.
24
25

EXAMINATION

RESUMED BY MS. SHUMATE:

Q Do you have someone in your office, at that time or now, named Brenda? A lady in your office named Brenda?

A There was a secretary named Brenda.

Q Would she have been dealing with --

A I have no idea.

Q Okay. So, if Mr. Sasser talks about having called Brenda at your office, and she was dealing with Intracorp, trying to get it paid, would that give you some concern, or would that be something you would expect your patients to be dealing with somebody like her on these type problems?

A Yes.

Q All right. Now, I do have a couple of follow-ups. He asked you about MRIs and EMGs and NCVs, would that be the best evidence. And I think you -- it's fair to say that it doesn't hurt to have the most information possible? Is that correct?

A That's correct.

Q The lack of your having had them at

the time, does that change your opinion about what you testified about his back pain and the necessity for the treatment and that kind of thing?

A No.

Q Now, if, in fact, I do show you that he had an MRI, in 1997, that showed some impingement on the L5 nerve roots on the lateral recesses bilaterally, not to be significantly changed from February of '96, no evidence of disc herniation, basically a lumbar MRI which was consistent with degenerative disc disease, and he also had a nerve conduction study performed by a neurologist, that showed chronic bilateral L5-S1 radiculopathy -- and these took place before you ever saw him. Because he had been treated for five years before you ever saw him.

A Right.

Q Do those two tests, what I read to you about those tests, change your opinion in any way?

MR. KNOTT: Object to the form and the predicate. And I'll just

put on the record that he doesn't have those in front of him --

MS. SHUMATE: Sure.

MR. KNOTT: -- to review the entire record. That the question is based on the summary.

Q Assume, hypothetically, that the -- I'll ask again. Assume, hypothetically, that the results of the nerve conduction study and EMG report, which are done by Hassan Kesserwani, the results read -- assume this is correct. The results read, "1. There is no evidence of polyneuropathy. 2. There is no evidence of carpal tunnel syndrome. 3. There is evidence of a mild chronic bilateral L5-S1 radiculopathy."

And then, assume he had an MRI in 1997 that showed impingement on the L5 nerve roots on the lateral recesses bilaterally, with no evidence of disc herniation.

Assume those statements are true, that there were MRIs and EMGs that said those things. Assume hypothetically. Does that change your opinion in any way?

MR. KNOTT: Object to the form and foundation and predicate of the hypothetical.

A Would you mind specifying what opinion you're asking --

Q The opinion I asked you about, whether he has back pain, in your opinion, that he's not faking, whether the treatment that you gave for him was necessary and related to that back pain, whether the problems with his legs, the pain he's having in his legs, and the need for the trigger point is related to a back jury.

A It does not change my opinion.

Q Do those tests bolster any of your opinions, in your mind, the fact that he had those and they showed those results? I should say, are they consistent with what you saw? Not bolster.

A Hypothetically --

Q Yes.

A -- if those MRI results and EMG/NCV results are present, and, hypothetically, someone reports back pain and leg pain, then, hypothetically, there can be a relationship.

1 Q And you were asked about angina,
2 coronary artery disease, kidneys, high blood
3 pressure, diabetes. In your medical opinion,
4 are any of those conditions the cause of his
5 back and leg pain?

6 MR. KNOTT: Object to the form and
7 the predicate and the
8 foundation of the hypothetical.

9 A Unlikely. I would have to say no.

10 Q Thank you. Now, the pain scale
11 that he indicated he had a six out of ten,
12 that's that one question that one day? Is
13 that correct?

14 A Right.

15 Q In your opinion, was the four years
16 of treatment -- almost four years of
17 treatment you rendered for Mr. Sasser, until
18 it was cut off in May of '04, was it a
19 successful pain management regimen for him,
20 in your opinion?

21 MR. KNOTT: Object to the form.
22 Foundation.

23 A Well, it really, I guess, depends
24 on how you define success. Success that his
25 pain scores didn't go up, that his pain

1 didn't make him -- that they didn't get
2 worse, that he didn't become more debilitated
3 as a result of his pain, I can't say, because
4 the only way to say that would be to go back
5 and go to that same time frame and remove all
6 the medication.

7 So, does the reporting of a pain score
8 on the last day of the visit of a five out of
9 ten versus a pain score on the first day
10 being a six out of ten imply success? Does
11 it imply that he didn't get worse? I don't
12 know.

13 Q Well, I guess that's what I'm
14 trying to get at. I guess the implication
15 could be, well, it's not necessary and it's
16 not helping him, because it only went from a
17 six to a five, from the beginning to the end.
18 But, am I correct that that's not your judge
19 of success nor Mr. Sasser's indication to you
20 that this wasn't helping him any, was it?

21 MR. KNOTT: Object to the form.

22 A I can't speak for Mr. Sasser's
23 mind.

24 Q He kept coming back.

25 A Well, one would assume that if

1 there is a series of events that's ongoing,
2 repetitive and routine, that if it's
3 unsuccessful or just not something that
4 somebody wants to do, that they will stop at
5 some point along the way. That's what I
6 would assume. I can't answer how someone
7 else would operate.

8 Q You did not come to the conclusion
9 during this time period that pain management
10 was not helping him, did you?

11 A I did not come to that conclusion.

12 Q And you did not cut him off
13 yourself, saying this isn't working, did you?

14 A I did not.

15 Q In fact, you anticipated he would
16 continue with pain management for some
17 indefinite period of time?

18 MR. KNOTT: Object to the leading.

19 Q Is that correct?

20 MR. KNOTT: Object to the leading.

21 Q He had another visit scheduled?

22 MR. KNOTT: Object to the leading.

23 A I intended for Mr. Sasser to
24 continue coming here, because I have a note
25 here on his trigger point injection procedure

1 note of 5-20-04, in which I report "Follow-up
2 already set." So, my assumption is that we
3 had requested the next appointment.

4 Q Okay. Do you have patients who
5 treat with you for years, and it's intended
6 or expected they're going to treat with you
7 'til something miraculously happens or they
8 die?

9 A Yes.

10 Q And that's part of the process of
11 pain management? Am I correct?

12 A In our practice, yes.

13 Q Was there anything about Mr. Sasser
14 that made you think that that was not going
15 to be the course for him?

16 A Well, I can't say. I mean, I
17 didn't anticipate stopping suddenly. But,
18 obviously, at any point in time -- you know,
19 I can't prognosticate what's going to happen
20 at any time in the future. So, my intent was
21 to continue treating Mr. Sasser as long as he
22 needed it.

23 Q Is the history he gave you
24 consistent with what you saw in him? I mean,
25 was there something about the history he gave

1 you of the mode of his injury that made you
2 go, hmm, that doesn't seem like what would
3 have caused this?

4 A The nature of his injury as
5 reported to me on the initial intake was
6 consistent with the nature of the pain
7 complaint at that time.

8 Q Is it consistent with the diagnosis
9 that Dr. McGahan had given him of lower back
10 pain, spinal stenosis, muscle spasms?

11 A Well, first of all, I would say
12 that, hypothetically, Dr. McGahan's diagnosis
13 of stenosis came from his receiving the
14 hypothetical MRI.

15 Q That's correct.

16 A He, on physical examination, would
17 be unlikely to make a strict diagnosis of
18 stenosis just on physical exam alone.

19 Q That would be something an MRI
20 would show?

21 A Yes.

22 Q That's the type of thing that an
23 MRI would diagnose?

24 A Would show. Yes.

25 MS. SHUMATE: Okay. That's all.

EXAMINATION

1
2
3 RESUMED BY MR. KNOTT:

4 Q Dr. Marsella, the question of his
5 complaints being consistent with the story he
6 reported to you, his story could also be --
7 or his complaints could also be consistent
8 with a number of alternate or other
9 explanations for how that pain came to be?
10 Is that right?

11 A That's correct.

12 Q In other words, your records
13 reflected lifting something at the G. E.
14 plant?

15 A Correct.

16 Q And that's one thing that could
17 coexist at the same time as his pain. That's
18 one possible explanation, I guess is one way
19 to say it?

20 A Well --

21 Q Is that what you mean when you say
22 "consistent"?

23 A No.

24 Q That's a possible explanation?

25 A Consistent, when I use that term,

1 when "A" is consistent with "B," means that
2 the report of, in our case, pain, makes sense
3 based on the report of some event. So,
4 that's what consistent means. Doesn't mean
5 that it necessarily, 100 percent, without
6 question, that there is a causative
7 relationship.

8 But, based on the nature of a particular
9 event and the nature of a particular
10 complaint, if it's reasonable -- if I
11 oftentimes see "B" as a result of "A," then
12 my experience leads me to believe that
13 there's a relationship.

14 Q But, as you testified earlier, it's
15 impossible to say, with certainty, that "A"
16 caused "B" in a case like this, where you
17 have a 1995 accident, and you saw him in 2000
18 with this presentation?

19 A Well, when a patient says -- when
20 we ask, "When did your pain begin," and they
21 give a date, day or date or whatever, and we
22 ask them what caused that, and they give an
23 event, we assume that the pain that they
24 present, that started on a given day, and the
25 event that it happened on a given day, is

1 related. The assumption is made. I don't
2 usually ask, "Well, have you ever had" --
3 well, no. I shouldn't say I don't usually
4 ask. But, if somebody says to me, my pain
5 began on this day, then I assume that that
6 pain wasn't there before that day. Do you
7 follow what I'm --

8 Q I do. On the other hand, a report
9 by a patient like Mr. Sasser, reporting that
10 a particular event caused his condition, it
11 would not change the way you treated that
12 condition -- right? -- because you're
13 treating the condition?

14 A That's correct.

15 Q It's not based on the event that
16 caused the condition? Is that fair?

17 A That's fair.

18 Q And so, although you, as a
19 physician, will assume that the patient's
20 report is correct, it's not a
21 medically-necessary determination that you're
22 making in terms of whether the patient's
23 history is accurate in terms of this event
24 caused the condition. That's not a
25 medically-necessary determination you make,

1 because it wouldn't affect your treatment.

2 Is that also a fair statement?

3 MS. SHUMATE: Object to the form of
4 the question.

5 A I'm going to rephrase your
6 question.

7 Q Okay.

8 A And make sure I rephrase it
9 correctly. What you're asking me is, would
10 it have mattered, the causative event,
11 whether it was a sneeze or lifting whatever
12 or twisting, you know, catching a 400-pound
13 marlin or whatever. Would it have mattered
14 how I treated the patient, based on
15 presentation of pain complaint? The answer
16 is no. I don't treat the cause. I treat the
17 effect.

18 Q And to extend that answer a step
19 further, the cause of the condition, it's not
20 medically necessary for you, as a physician,
21 to determine the cause?

22 A That's correct.

23 Q And so, although you're able to
24 assume that a patient's report to you is
25 accurate, that's not the primary goal in your

1 wouldn't matter how I treated that pain
2 condition.

3 So, yes, I can offer an opinion about
4 cause and effect, but it doesn't matter what
5 I do. It doesn't matter in what I do, is
6 what I should say.

7 Q I believe, earlier, you testified
8 that it's impossible to say, with certainty,
9 whether this particular event that was
10 reported to you was, in fact, the cause of
11 the conditions that you treated Mr. Sasser.
12 And if there's a question about that, we can
13 -- the court reporter can read it back. Do
14 you remember your testimony that way?

15 A No. I don't remember.

16 MS. SHUMATE: Object to that
17 question.

18 Q Okay. Should we read that back?

19 MR. KNOTT: Do you remember where
20 that was?

21 COURT REPORTER: I certainly don't.
22 I don't know how long it would
23 take me to go through all the
24 notes.

25 Q Setting aside for a moment the

1 treatment, to determine whether the patient
2 is accurate in reporting what caused the
3 condition?

4 A That's correct.

5 Q And so, that's not a conclusion
6 that you, as a physician, reach with medical
7 certainty, whether or not an event caused the
8 condition, because it's not a medical
9 opinion?

10 MS. SHUMATE: Object to the form of
11 the question. He could reach
12 that opinion if he's asked.

13 A That's sort of a -- to me, sort of
14 a multipart question.

15 Q Okay. If you can break your answer
16 up, then that's --

17 A Certainly. From the standpoint of,
18 does the cause of a particular pain
19 condition, regardless, have any impact on how
20 I treat a given pain condition, no.

21 If asked for an opinion about whether a
22 particular event caused the onset of a
23 particular pain condition, it doesn't matter
24 -- I can say "yes" or "no," given the right
25 -- you know, given the information, but it

1 question of the event that caused the
2 conditions, is it your understanding that Mr.
3 Sasser has been diagnosed with degenerative
4 disc disease in his lumbar spine?

5 A Well, if a hypothetical MRI can be
6 relied upon to relate to a specific patient
7 -- is that possible? I mean, is that
8 allowable? As I understand it, in earlier
9 questioning, an allusion was made to an MRI,
10 but then it was hypothesized later that, if
11 an MRI showed this.

12 Well, if I had an MRI report that had
13 Mr. Sasser's name on it, and I read the
14 report, and it said that there was
15 degenerative disc disease, then I would say
16 that the patient has degenerative disc
17 disease. So, does that answer your question?

18 Q Degenerative disc disease can have
19 a number of causes? Is that right?

20 A Yes.

21 Q And it can also occur without any
22 particular outside cause?

23 A That's correct.

24 Q It can be a condition that just
25 naturally develops in the person's body as a

1 process of aging? Is that correct?

2 A That's correct.

3 Q And let me ask you about lumbar
4 stenosis. Is lumbar stenosis also a
5 condition that can develop without an outside
6 cause?

7 A Well, stenosis is narrowing. So,
8 that implies that the normal caliber of the
9 spinal canal and the normal caliber of the
10 openings out of the spine, called foramina,
11 when those are smaller than they should be,
12 that is stenosis.

13 Now, the stenosis comes as a result of
14 something narrowing the caliber of those
15 cavities, whether it's an overgrown capsule
16 around a disc -- around a joint, whether it's
17 a disc that's poking out, whether it's the
18 fact that the spine bones come closer
19 together as a result of the degeneration of
20 the disc, whatever.

21 So, to extend that process, something is
22 going on in structures surrounding the
23 openings for the nerve roots, nerves, spinal
24 cord, whatever. What that is doesn't
25 necessarily matter. But the fact that there

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1 is a narrowing, which is then known as
2 stenosis, occurs.

3 If those events occur spontaneously or
4 through the natural process of aging or
5 whatever, injury, whatever, that results in
6 stenosis, then, yes. If the event that
7 caused the stenosis is spontaneous, then, in
8 a sense, the stenosis can also be
9 spontaneous.

10 Q And by "spontaneous," you're
11 referring to what we were talking about in
12 terms of degenerative disc disease?

13 A No distinct cause. A natural
14 process of aging, or could be a series of
15 events.

16 Q So, conditions like degenerative
17 disc disease and lumbar stenosis can both
18 occur in a person who has no injury, no
19 accident or event at all?

20 A Sure.

21 Q And by looking at an MRI, a
22 physician can't determine, necessarily,
23 whether this person's degenerative disc
24 disease and lumbar stenosis was caused by an
25 event or caused by the natural process of

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1 aging? Is that correct?

2 A That's correct.

3 Q And it feels the same -- is that
4 correct? -- to the patient?

5 A I would have to defer to the
6 patient.

7 Q Okay. And Mr. Sasser's complaints
8 of pain and his physical complaints and the
9 descriptions of how his condition felt to
10 him, in your office, was that consistent with
11 a person who had pain as a natural process of
12 aging?

13 MS. SHUMATE: Object to the form of
14 the question.

15 A I'm not real sure I understand your
16 question. In other words, if you're asking
17 me, just as the process of having more
18 birthdays, would one have the kind of pain
19 that Mr. Sasser presented with --

20 Q I don't mean necessarily.

21 A Right.

22 Q But, is it consistent with --

23 A Is it possible? Well, I can't
24 answer the question the way you asked it.

25 Q Okay. Assume Mr. Sasser had not

1 told you that he had hurt his back lifting
2 something in 1995. Without that one piece of
3 verbal history from the patient, would your
4 records give you anything to draw an opinion
5 concerning any particular event being the
6 cause of his condition?

7 A Well, with a complaint of low back
8 pain and leg pain, and somebody said, "I have
9 back pain and leg pain, and that's all I'm
10 going to tell you. You know. Now your job
11 is to find out how to help me," what I would
12 do, is, if I couldn't -- if I didn't have
13 access to previous studies like MRIs, EMGs or
14 other X-rays or things like that, I would
15 order them to determine.

16 Because the nature of a complaint --
17 oftentimes what we see is the particular
18 nature of a complaint goes along with some
19 physical finding, radiographic,
20 electrodiagnostic, whatever. So, then I
21 would try to find if there was a reason for
22 that type of pain, stenosis, degenerative
23 disc disease, whatever.

24 So, to say, does everybody have low back
25 pain and leg pain as they get older, no. To

1 ask, is onset of low back pain and leg pain
2 consistent with getting older, or could it be
3 the result of getting older, not in and of
4 itself, I don't think. There usually is some
5 reason, typically spinal reason, for specific
6 complaints of low back and leg pain.

7 Q And in this particular case, where
8 you did have Mr. Sasser giving you his own
9 account of lifting something in 1995, you
10 felt it was adequate to rely on that, and did
11 not go back to request or order MRIs or NCVs
12 or EMGs? Is that correct?

13 A That's correct.

14 Q Have you met with Mr. Sasser's
15 attorney, Ms. Shumate, before today?

16 A On this case?

17 Q Yeah. On this case, I suppose.
18 Yes.

19 A I don't recall.

20 Q Or had any communications with her?

21 A Not that I recall, no.

22 Q Do you charge a fee for giving this
23 deposition in this case?

24 A I do.

25 Q And what is that fee?

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1 A We charge \$1200.00 an hour.

2 Q Okay. Do you know whether Mr.
3 Sasser has had treatment by any neurosurgeons
4 or neurologists?

5 A I don't know that.

6 Q Do you think a neurosurgeon with
7 access to MRIs or NCVs or EMGs would be in a
8 good position to form an opinion with regard
9 to the nature and cause of the type of
10 conditions that Mr. Sasser reported to your
11 office for?

12 MS. SHUMATE: Object to the form of
13 the question.

14 A I can't say specifically. I would
15 assume that a surgeon, neurosurgeon, who has
16 access to MRIs and EMG/NCVs of a patient
17 would be able to relate the physical findings
18 on those studies to the nature of a pain
19 condition.

20 But, as to the cause of the physical
21 findings on the studies, unless there were
22 similar studies prior to a given event that
23 you could compare, then I don't know that you
24 could make -- I can't imagine anybody,
25 neurosurgeon or anybody, being able to state

1 an opinion as to cause/effect.

2 Q Do you get patients referred to you
3 by neurosurgeons?

4 A Yes.

5 Q And when that happens, is there
6 some sort of exchange of information between
7 you and the neurosurgeon?

8 A Typically.

9 Q And so, are you, I guess, in the
10 business of relying on neurosurgeons'
11 opinions in this regard to a certain degree
12 in your medical judgments?

13 A Yes.

14 MR. KNOTT: That's all I have right
15 now. But Bill had made an
16 objection to the deposition
17 before, in his letter to you,
18 and I'll reserve the right, on
19 the basis of that objection,
20 and based on the --

21 MS. SHUMATE: He didn't object to
22 the court. He wrote me a
23 letter and said, if you're
24 going to use him as an expert,
25 I'm going to object to the

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1 court. And I said, if you're
2 going to object, please do so
3 before I pay Dr. Marsella. And
4 there was no objection given.

5 MR. KNOTT: And I'm going to
6 reserve the right --

7 MS. SHUMATE: You can object to any
8 evidence at the trial. I mean,
9 that's your business.

10 MR. KNOTT: I'm going to reserve
11 the right to continue this
12 deposition at a later date, on
13 the basis of the lack of
14 designation of Dr. Marsella as
15 an expert in advance of the
16 deposition.

17 MS. SHUMATE: You can reserve the
18 right to ask the judge to let
19 you come back and take it all
20 you want. I'm not going to
21 agree to any kind of
22 reservation of you continuing
23 this for that purpose.

24 MR. KNOTT: And that's on the
25 record.

MS. SHUMATE: Thank you. I have one question.

EXAMINATION

RESUMED BY MS. SHUMATE:

Q In this case, you didn't rely on any neurosurgical opinions, because there were none provided to you when you were treating him? Is that correct?

A That's correct.

Q And when you rely on the opinion of a neurosurgeon or a neurologist, it's on a case-specific basis for that particular patient? Is that correct?

A That's correct.

Q You would not, in this case, defer to some neurosurgeon, neurologist, pain management, anybody else's opinion, just because they reviewed records and had a different opinion with you regarding Mr. Sasser, would you?

A No.

MS. SHUMATE: Okay. Thank you. That's all.

radiographic studies, magnetic resonance imaging studies, electromyographic studies, as supportive evidence of the nature -- of the cause of the nature of the pain. But as to the cause of the findings of the studies, per se, another physician's having that information wouldn't make any difference, in my opinion, about the patient's pain condition. Does that answer your question?

Q And, specifically, when you refer to your opinion regarding the patient's pain condition, what do you mean by that, just for clarity?

A Well, low back pain and leg pain.

Q So, it wouldn't change your opinion regarding the fact that he's having leg pain and low back pain?

A It would just substantiate it.

Q It would substantiate it.

A That it's a reasonable pain response to a physical finding on diagnostic study. In other words, the presence or absence of spinal stenosis, degenerative disc disease, doesn't, in and of itself, necessitate the presence of back pain, leg

EXAMINATION

RESUMED BY MR. KNOTT:

Q Would you defer to the opinion of a physician who had, at his disposal, additional records which were not at your disposal?

MS. SHUMATE: I'm going to object to the form of the hypothetical. You haven't laid a predicate for it properly.

Q I believe plaintiff's attorney asked you to assume certain studies had been performed on Mr. Sasser. If a physician had, at his disposal, studies of that nature regarding a patient, regarding Mr. Sasser, would you defer to that physician's opinion, if that physician's opinion was informed by those additional studies?

MS. SHUMATE: Object to the form of that question.

A Well, I wouldn't defer to the opinion as far -- defer to an opinion as far as cause and effect. I would certainly take any additional information, such as

pain. The fact that they're both present at the same time is consistent.

Q Assume a physician were to review the MRI findings and conclude that the findings of the MRI were not consistent with the nature of subjective complaints, as being the cause of those subjective complaints. Would you defer to an opinion such as that being based on a neurologist reviewing an MRI finding?

MS. SHUMATE: Object to the form of the question.

A Not necessarily. Opinions are opinions. I mean, we form our opinions based on lots of things. But, you know, what another physician's -- not to say that I don't appreciate input from other physicians, because I rely on that heavily in some cases. Whether I will throw my opinion out the window and say, well, whatever you say is right, I wouldn't normally do that.

Q If my question implied that another doctor was better at forming the opinion, then that's not what it was meant to imply. But, in terms of the information that opinion

1 would be based on, if a neurologist were able
2 to review an MRI that you had not had the
3 opportunity to review -- and assume a
4 neurologist did review the MRIs that you were
5 not able to personally review.

6 And assume further that that neurologist
7 or neurosurgeon concluded, based on the
8 review of that MRI that you had not had the
9 opportunity to review, that the neurologist
10 concluded that the MRI findings regarding the
11 patient's back were not consistent with the
12 patient's complaints -- with being the cause
13 of the patient's complaints in his leg.

14 Would you defer to that opinion as being
15 based on more information that was not at
16 your disposal?

17 MS. SHUMATE: Object to the form of
18 the hypothetical.

19 A Assuming that the nature of the
20 pain complaint to the neurologist and the
21 nature of the pain complaint to me were
22 exactly the same, I would consider it. I
23 can't say whether I would defer to it or not,
24 because that situation wasn't present.

25 Q And in considering it, I guess,

1 would it be appropriate for you, at that
2 time, to withhold judgment until you had the
3 opportunity to review those same MRIs that
4 the neurologist or the neurosurgeon had
5 reviewed, so you could formulate your own
6 opinion based on that evidence?

7 MS. SHUMATE: Object to the form of
8 the question.

9 A It would certainly be nice to have
10 the data available.

11 Q And that's something that you think
12 would be appropriate to do in that
13 eventuality?

14 A Yes.

15 MS. SHUMATE: Object to the form of
16 the question.

17 Q Was that a "yes"?

18 A Yes.

19 MR. KNOTT: That's all I have right
20 now.

21

22 EXAMINATION

23

24 RESUMED BY MS. SHUMATE:

25 Q Assume, hypothetically, that there

1 was a workers' comp case filed. A man claims
2 he got hurt on the job. He settled his case
3 with the workers' comp company. And part of
4 that judgment, in a court of law, is that
5 they are to continue to pay for medical
6 treatment related to his back injury.

7 Assume also, subsequent to that, several
8 years after that, there's a dispute as to
9 whether his complaints and his treatment is
10 related, and the judge enters a second order
11 saying, I find he was injured on the job, in
12 his back, in September of '05, and
13 Dr. McGahan relates that to his work, and,
14 thus, they are responsible for future
15 medicals for that low back injury. And then,
16 you see him starting in 2000 from Dr. McGahan
17 referring him for that low back pain.

18 Based on those hypotheticals, are you
19 treating him for the back pain he sustained,
20 that Dr. McGahan said was related, that the
21 judge has ordered was related?

22 MR. KNOTT: Object to the form and
23 the predicate.

24 Q Is there anything different, to
25 your knowledge, you're treating him for than

1 what he was sent here for by Dr. McGahan for
2 that back injury?

3 MR. KNOTT: Object to the form and
4 the predicate and the
5 foundation. It misstates the
6 factual record.

7 Q You can still answer the question.

8 A Assuming all that is correct --

9 Q Sure.

10 A -- yes.

11 MS. SHUMATE: Thank you. That's
12 all.

13 (Whereupon, Plaintiff's Exhibits 1,
14 2 and 3 marked for
15 identification.)

16

17 END OF DEPOSITION

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PLAINTIFF'S EXHIBIT NO. 1

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1 STATE OF ALABAMA
2 HOUSTON COUNTY
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4 I, Stacey Watkins, RPR, and Notary
5 Public, State at Large, do hereby certify
6 that the foregoing transcript, pages 1
7 through 131, is a true and correct transcript
8 of the testimony and proceedings taken at
9 said time and place; and that the same was
10 taken down by me in stenograph shorthand,
11 and transcribed by me personally or under
12 my personal supervision.

13 I further certify that I have no
14 interest in this matter, financial or
15 otherwise, or how it may develop or what
16 its outcome may be. I further certify that
17 I am not of counsel for any of the parties,
18 nor am I related to counsel or litigants or
19 associated with anyone connected with this
20 cause to my knowledge.

21 Witness my hand this 24th day of July,
22 2007.
23
24

25 _____
RPR, Notary Public,
State at Large

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